

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2040

CERTIFICATE OF DEATH

Reg. Dist. No.

12032

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAURECE GRACE</b>				c. LENGTH OF STAY IN 1b <b>1 month</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>HARFORD MEMORIAL HOSPITAL</b>				e. STREET ADDRESS <b>Sandy Hill Farm</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>MARION KATHERINE BAILEY</b>				4. DATE OF DEATH Month Day Year <b>FEB. 26 1960</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/5/11</b>	9. AGE (In years last birthday) yrs. <b>48</b>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>	
13. FATHER'S NAME <b>John Koop</b>				14. MOTHER'S MAIDEN NAME <b>ADALINE DOLAN</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>W.W. 3</b>				16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>John J. Bailey, Sandy Hill Farm, Harford, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of liver</b> <b>156.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>—</b> DUE TO (c) <b>—</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 months or longer</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>—</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>—</b>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>—</b>	
20f. (City or town) (County) (State) <b>—</b>				20g. (City or town) (County) (State) <b>—</b>			
21. I certify that I attended the deceased from <b>1/27/60</b> to <b>Feb. 26/60</b> , that I last saw the deceased alive on <b>Feb. 26/60</b> , and that death occurred at <b>12:55 PM</b> , from the causes and on the date stated above.							
21. I certify that I attended the deceased from <b>1/27/60</b> to <b>Feb. 26/60</b> , that I last saw the deceased alive on <b>Feb. 26/60</b> , and that death occurred at <b>12:55 PM</b> , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <b>211 N. Union Ave. Baltimore Md.</b>			
DATE SIGNED <b>2/26/60</b>				DATE SIGNED <b>2/26/60</b>			
ACTUAL SIGNATURE <b>Edward C. Hooper, M.D.</b>				PHYSICIAN'S NAME (Type) <b>Edward C. Hooper, M.D.</b>			
22a. BURIAL (CREMATION, REMOVAL) (Specify) <b>2/29/60</b>				22b. DATE THEREOF <b>2/29/60</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Greenmount</b>				22d. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Permyrington &amp; Son, Harold Chase, Md.</b>				24a. REC'D BY REGISTRAR <b>DATE MAR 2 '60</b>			
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>				24c. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2000

DATE OF DEATH

<p>1. Name of deceased</p> <p>2. Sex</p> <p>3. Age</p> <p>4. Date of birth</p> <p>5. Place of birth</p> <p>6. Usual residence</p> <p>7. Date of death</p> <p>8. Time of death</p> <p>9. Place of death</p> <p>10. Cause of death</p> <p>11. Nature of disease</p> <p>12. Duration of disease</p> <p>13. Date of admission to hospital</p> <p>14. Name of attending physician</p> <p>15. Name of hospital</p> <p>16. Name of registrar</p> <p>17. Signature of registrar</p> <p>18. Date of registration</p>	
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MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 19

2000

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 19

2000

## 2041 CERTIFICATE OF DEATH

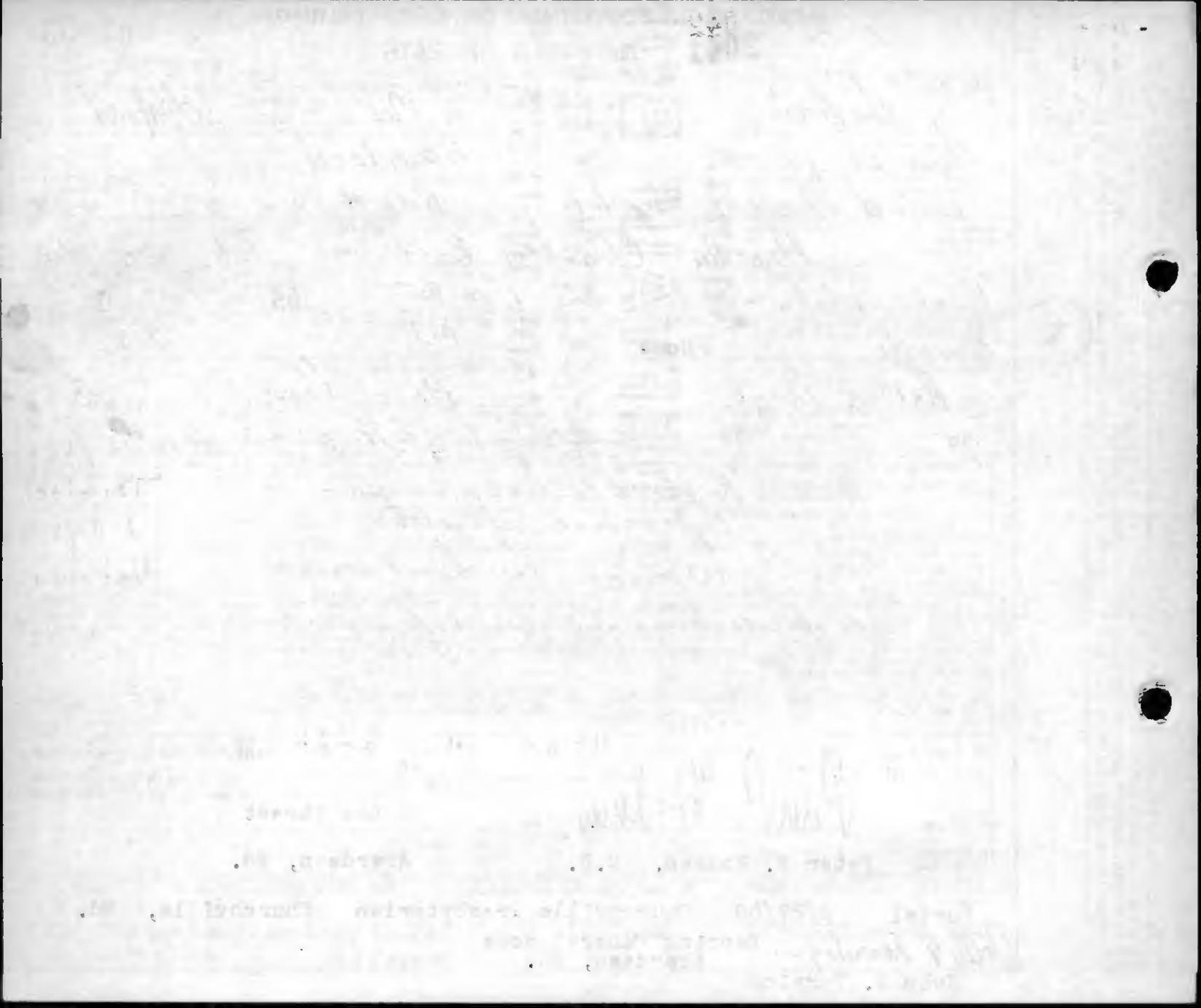
Reg. Dist. No.

02033

1. PLACE OF DEATH a. COUNTY <i>Charford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Name de Grace</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Aberdeen</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Harford Memorial Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Annella</i> Middle <i>Clara</i> Last <i>Bodt</i>		4. DATE OF DEATH Month <i>Feb.</i> Day <i>24</i> Year <i>1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-12-95</i>
9. AGE (In years last birthday) <i>65</i> yrs.		10. IF UNDER 1 YEAR Months <i>65</i> Days <i>65</i> Hours <i>65</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S.</i>	
13. FATHER'S NAME <i>Arthur Trago</i>		14. MOTHER'S MAIDEN NAME <i>Alice Cole</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>INFORMANT</i>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Ruptured cardiac aneurysm</i> <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Myocardial infarction</i> DUE TO (c) <i>arteriosclerotic heart disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Terminal</i> <i>2 days</i> <i>Unknown</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Acute pyelonephritis and bronchopneumonia</i>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <i>a. m.</i> <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1-16-59</i> to <i>2-24-60</i> , that I last saw the deceased alive on <i>2-24-60</i> 19 <i>60</i> , and that death occurred at <i>12:45</i> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>8 Law Street</i> DATE SIGNED	
ACTUAL SIGNATURE <i>Peter P. Rodman</i> M.D.		DATE SIGNED	
PHYSICIAN'S NAME (Type) <i>Peter P. Rodman, M.D.</i>		<i>Aberdeen, Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>2/27/60</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Churchville Presbyterian</i>		22d. LOCATION (City, town, or county) (State) <i>Churchville, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John G. Tarring</i>		24a. REC'D BY REGISTRAR <i>FEB 29 '60</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Evans</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2066

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Forest Hill</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>32 Bel Air</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Grafton Shop Road</u>		d. STREET ADDRESS <u>1 Broadway</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>FANNIE</u> Middle <u>A.</u> Last <u>CAIN</u>		4. DATE OF DEATH Month <u>February</u> Day <u>26</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 26, 1865</u>
9. AGE (In years last birthday) yrs. <u>95</u>		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	
11. BIRTHPLACE (State or foreign country) <u>Harford Co, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Judge James M. Cain</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Kean</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>John O'Neill</u>		Address <u>Forest Hill, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause, or line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 1977</u> to <u>Feb 26</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Feb 25</u> , 19 <u>60</u> , and that death occurred at <u>5:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles Richardson, Jr. M.D.</u>		ADDRESS (Street, city or town, state) <u>Bellview Rd</u>	
PHYSICIAN'S NAME (Type) <u>Charles Richardson, Jr. M.D.</u>		DATE SIGNED <u>  </u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 29, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Ignatius Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hickory, Harford Co, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph W. Foster</u>		24a. REC'D BY REGISTRAR <u>FEB 29 1960</u>	
ADDRESS <u>W. Broadway &amp; Williams St Bel Air, Maryland</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MASSACHUSETTS  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS  
CERTIFICATE OF DEATH

MASSACHUSETTS  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS  
CERTIFICATE OF DEATH

NAME OF DECEASED  
AGE  
SEX  
DATE OF BIRTH  
DATE OF DEATH  
PLACE OF BIRTH  
PLACE OF DEATH  
CAUSE OF DEATH  
MANNER OF DEATH  
OCCUPATION  
EDUCATION  
RELIGION  
MARRIAGE  
SINGLE  
MARRIED  
WIDOWED  
DIVORCED  
REMARKS

MASSACHUSETTS  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS  
CERTIFICATE OF DEATH

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 TDM

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02035

2067

## CERTIFICATE OF DEATH

Reg. Dist. No.....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural-Street</u>		LENGTH OF STAY (in this place) <u>5 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural-Street</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>MARY LANE CARPENTER</u>				<b>4. DATE OF DEATH</b> (Month) <u>February</u> (Day) <u>23</u> (Year) <u>1960</u>			
<b>5. SEX</b> <u>F</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Widowed</u>	<b>8. DATE OF BIRTH</b> <u>June 20, 1890</u>		<b>9. AGE last birthday</b> <u>69 yrs.</u>	<b>IF UNDER 1 YEAR</b> Months _____ Days _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Laura Jane Ware</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>Abraham Reger</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Laura Jane Ware</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> -----		<b>17. INFORMANT &amp; ADDRESS</b> <u>Mrs. Clifford Hopkins, Street, Md.</u>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>16. MEDICAL CERTIFICATION</b>	
420.1 IMMEDIATE CAUSE (A) <u>Acute coronary Thrombosis c</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 hr.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>massive infarction.</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Hypertensive cardiovascular disease</u>						10 years +	
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE</b> (Home, farm, factory, OF INJURY street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify</b> that I attended the deceased from <u>2 March, 1959</u> , to <u>23 Feb, 1960</u> , that I last saw the deceased alive on <u>23 Feb, 1960</u> , and that death occurred at <u>3:30 P.M.</u> from the causes and on the date stated above.							
<b>SIGNATURE</b> <u>Edwin W. Whitford Jr M.D.</u>				<b>ADDRESS</b> (Street, city, town, state) <u>Whitford, Maryland</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>				<b>DATE THEREOF</b> <u>Feb. 26, 1960</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Bethlehem</u>	
<b>24. REC'D BY REGISTRAR</b> <u>Feb 25 '60</u>				<b>REGISTRAR'S SIGNATURE</b> <u>Charles S. Kneass</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>John H. Hopkins</u>	
				<b>ADDRESS</b>		<u>Delta, Pa.</u>	

This form should be filled out by a physician or other qualified person who has examined the body of the deceased and is familiar with the facts of the case. It should be filled out as soon as possible after death, and should be filed in the office of the Registrar of the Department of Health, Baltimore, Maryland. The form should be filled out in ink, and should be signed by the physician or other qualified person who has examined the body of the deceased. The form should be filled out in the following manner:

# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD CERTIFICATE OF DEATH

Reg. Dist. No.

1. Name of Deceased

2. Sex

3. Age

4. Date of Birth

5. Place of Birth

6. Occupation

7. Cause of Death

8. Date of Death

9. Place of Death

10. Signature of Physician

11. Signature of Registrar

12. Signature of Coroner

13. Signature of Medical Examiner

14. Signature of Health Officer

15. Signature of Other Official

16. Signature of Other Official

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99. Signature of Other Official

100. Signature of Other Official

**MEDICAL CERTIFICATION**

VS A15 (4)  
ISM 10/57

CERTIFICATE OF DEATH

WILLIAM B. O'NEILL

1901

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Blank form area for recording death details, including fields for name, age, sex, date of death, and cause of death.

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **14 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## CERTIFICATE OF DEATH

02057

Reg. Dist. No.....

2043

1. PLACE OF DEATH COUNTY <u>HARFORD</u> MARYLAND CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAYREDE GRACE</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>HARFORD MEMORIAL HOSPITAL</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>HARFORD</u> CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL HAYREDE GRACE</u> STREET ADDRESS (If rural give location) <u>EARLTON Road</u>			
3. NAME OF DECEASED (Type or Print) <u>JENSIE</u> (First) <u>PEARL</u> (Middle) <u>DEBONIS</u> (Last)				4. DATE OF DEATH <u>FEB. 22</u> (Month) (Day) (Year) <u>1960</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>MAR. 13, 1892</u>	9. AGE last birthday <u>67</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>NO.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>FIELDS HAS H</u>				14. MOTHER'S MAIDEN NAME <u>ELIZA KIRK</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT & ADDRESS <u>NICHOLAS DEBONIS HAYREDE GRACE MD</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) <u>Coronary thrombosis.</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>A. S. C. D. D.</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>-</u>						18. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH <u>Sudden.</u> <u>?</u>	
19a. DATE OF OPERATION <u>-</u>						19b. MAJOR FINDINGS OF OPERATION <u>Diabetes Mellitus. Influenza</u>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. of work <input type="checkbox"/> Not white of work <input type="checkbox"/>		21e. INJURY OCCURRED While of work <input type="checkbox"/> Not white of work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb. 15th, 1960</u> , to <u>Feb. 22nd, 1960</u> , that I last saw the deceased alive on <u>Feb. 22nd, 1960</u> and that death occurred at <u>10:30 A.M.</u> from the causes and on the date stated above. SIGNATURE <u>[Signature]</u> ADDRESS (Street, city, town, state) <u>211 E. Union Ave. - House of Grace, Md. 21226</u> DATE SIGNED <u>2/22/60</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>2-25-1960</u>		NAME OF CEMETERY OR CREMATORY <u>BEL AIR MEMORIAL GARDENS</u>		LOCATION (City, town, or county) (State) <u>HARFORD CO. MD</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>A. Madison Mitchell</u>		ADDRESS <u>Hayre de Grace, Md.</u>	
DATE <u>FEB 24 '60</u>							



2068

CERTIFICATE OF DEATH

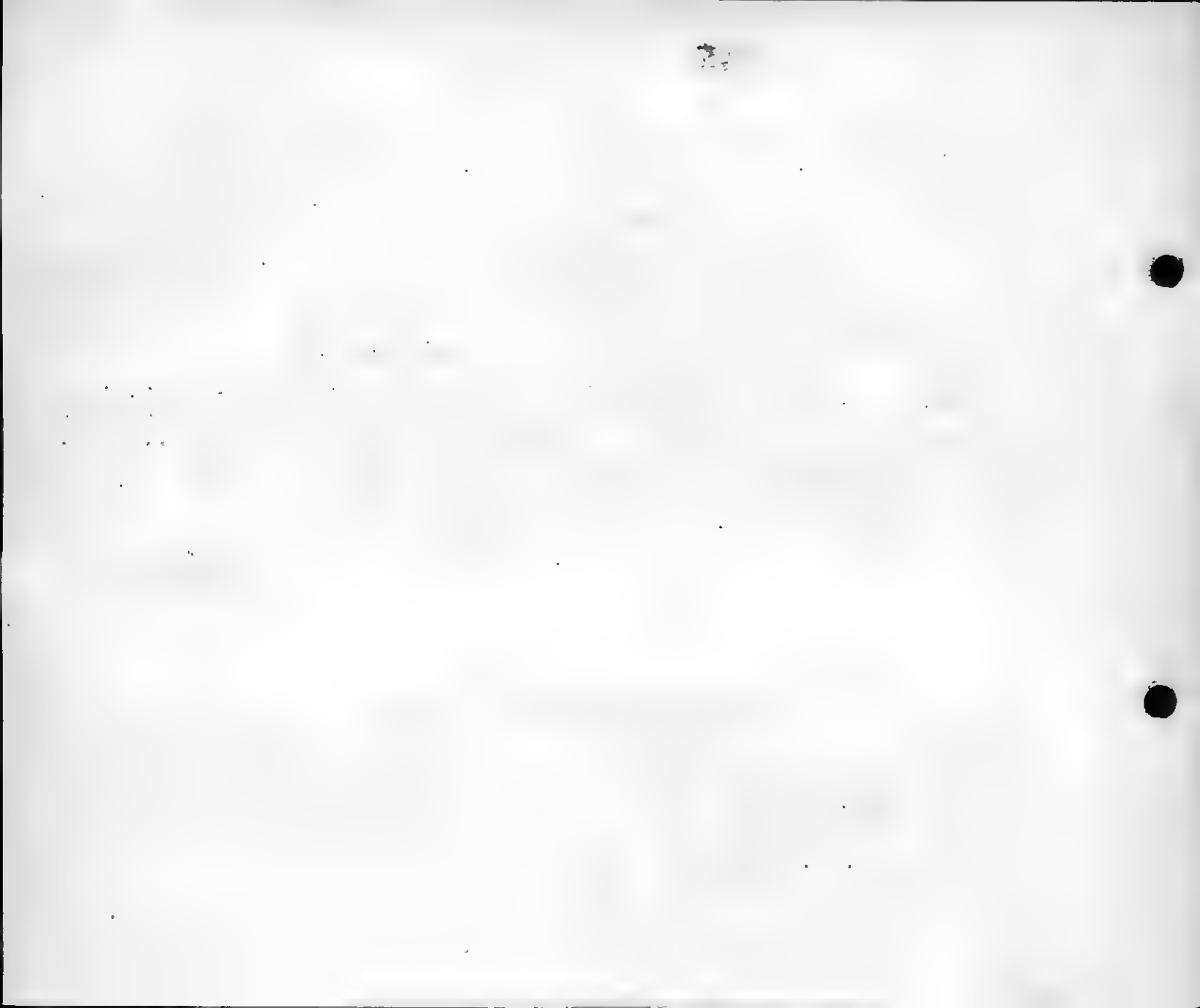
02038

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>HARFORD</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CARDIFF</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CARDIFF</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>TURA LEO LA DELP</b>		4. DATE OF DEATH Month Day Year <b>FEB. 5, 1960</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-13-1908</b>
9. AGE (In years (last birthday) yrs.) <b>51</b>		10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
11. BIRTHPLACE (State or foreign country) <b>WHITEFORD, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ROBERT W. LLOYD</b>		14. MOTHER'S MAIDEN NAME <b>GEORGIANNA BEATTIE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>C. LEATUS DELP, CARDIFF, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of cervix with lung metastasis</b> <b>171X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pneumonia - 2 weeks</b> INTERVAL BETWEEN ONSET AND DEATH <b>Known 1 yr.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 24. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <b>1:30 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Edwin W. Whiteford Jr. MD. M.D. 5 Feb 60</b>			
ACTUAL SIGNATURE <b>Edwin W. Whiteford Jr. MD. M.D.</b>		PHYSICIAN'S NAME (Type) <b>EDWIN W. WHITEFORD WHITEFORD, MD.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>2-8-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>SLATE RIDGE</b>		22d. LOCATION (City, town, or county) (State) <b>DELTA, PA.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John H. Harkins, Delta, Pa.</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 9 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			







## 2069 CERTIFICATE OF DEATH

Reg. Dist. No. 02040

1. PLACE OF DEATH a. COUNTY <b>Harford</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen</b>		c. LENGTH OF STAY IN 1b <b>7 hours</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>US Army Hospital Aberdeen Proving Ground, Md</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>DOHERTY</b> Last <b>DOHERTY</b>		4. DATE OF DEATH Month <b>February</b> Day <b>6</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5 Feb 60</b>
9. AGE (In years last birthday) yrs		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>49</b>	11. IF UNDER 24 HRS Hours <b>7</b> Min <b>49</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>N/A</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
13. FATHER'S NAME <b>William Joseph Doherty Jr</b>		14. MOTHER'S MAIDEN NAME <b>Barbara Ann Welch</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>N/A</b>	
17. INFORMANT <b>Father</b>		Address <b>115 N Rodman Road Aberdeen, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Immaturity</b> <b>776X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>7 hrs 49 min</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>5 Feb</b> , 19 <b>60</b> , to <b>6 Feb</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>6 February</b> , 19 <b>60</b> , and that death occurred at <b>3:30 A.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Charles H. P. Westfall</b>		ADDRESS (Street, city or town, state) <b>US Army Hospital</b> DATE SIGNED <b>6 Feb 60</b>	
PHYSICIAN'S NAME (Type) <b>CHARLES H P WESTFALL Maj MC</b>		<b>Aberdeen Proving Ground, Maryland</b>	
22a. BURIAL, CREMATION, or other disposal (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Feb. 8th 1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Post Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Aberdeen Proving Gr. Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John F. Barry</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 10 '60</b>	
ADDRESS <b>Aberdeen, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur J. Frank</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2150213XUO



## CERTIFICATE OF DEATH

Reg. Dist. No.

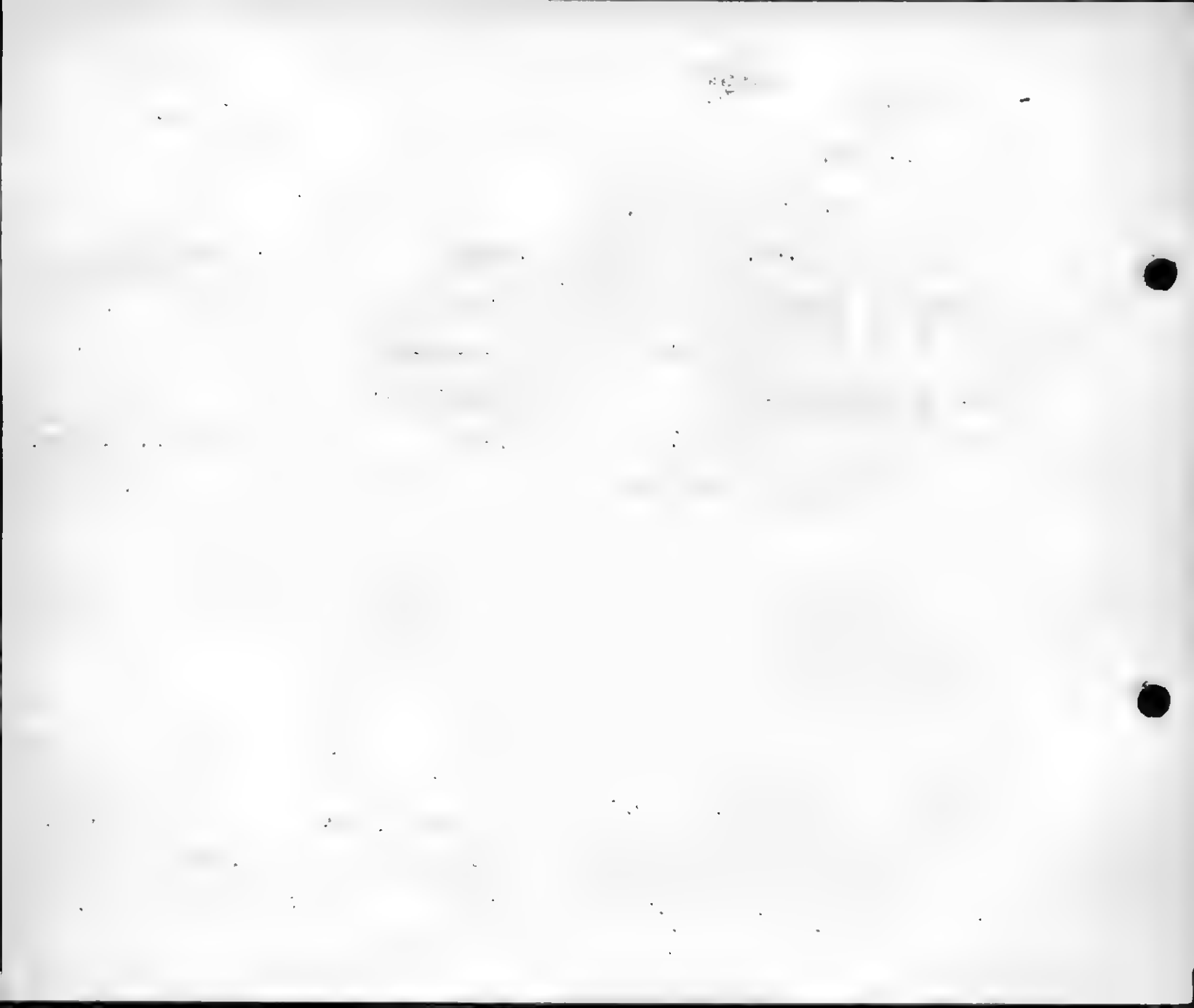
2070

1. PLACE OF DEATH a. COUNTY <b>Harford</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen</b>		c. LENGTH OF STAY IN 1b <b>7 hours</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>US Army Hospital Aberdeen Proving Ground, Md</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOAN</b> Middle <b>DOHERTY</b> Last <b>DOHERTY</b>		4. DATE OF DEATH Month <b>February</b> Day <b>6</b> Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5 Feb 60</b>
9. AGE (In years last birthday) yrs <b>7</b>		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>16</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>N/A</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
13. FATHER'S NAME <b>William Joseph Doherty Jr</b>		14. MOTHER'S MAIDEN NAME <b>Barbara Ann Welch</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>N/A</b>	
17. INFORMANT <b>Father</b>		Address <b>115 N Rodman Road Aberdeen, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Immaturity</b> <b>776X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>7 hrs 16 min</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5 Feb</b> , 19 <b>60</b> to <b>6 Feb</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>6 February</b> , 19 <b>60</b> , and that death occurred at <b>3:30 A</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <b>Charles H P Westfall</b> M.D. <b>US Army Hospital</b> <b>6 Feb 60</b> PHYSICIAN'S NAME (Type) <b>CHARLES H P WESTFALL Maj MC</b> <b>Aberdeen Proving Ground, Maryland</b>			
22a. BURIAL, CREMATION OR REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<b>Buried</b>	<b>Feb. 8th 1960</b>	<b>Post Cemetery</b>	<b>Aberdeen Proving G. Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John G Darrington Aberdeen Md</b>		24a. REC'D BY REGISTRAR <b>FEB 10 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>

2250214XUO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2045

## CERTIFICATE OF DEATH

Reg. Dist. No.

02042

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>	
c. LENGTH OF STAY IN 1b <u>17 days</u>		d. STREET ADDRESS <u>106 ALTON ST.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Paul</u> Middle <u>J.</u> Last <u>ERNST</u>		4. DATE OF DEATH Month <u>2/6</u> Day <u>19</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/23/1885</u>
9. AGE (in years last birthday) <u>74</u> yrs		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Research Physicist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>A.P.H.</u>	
11. BIRTHPLACE (State or foreign country) <u>Austria</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Paul G. Ernst</u>		14. MOTHER'S MAIDEN NAME <u>Steffanie Singer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Bertirude Ernst</u> Address <u>1023 Cross Drive Alexandria Va</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 450.1 IMMEDIATE CAUSE (a) <u>Gangrene right leg.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Impaired atherosclerosis</u> (c) <u>Generalized arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-21</u> , 1960, to <u>2-6</u> , 1960 that I last saw the deceased alive on <u>2-6</u> , 1960, and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Chas. H. Waldman</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type)			
22a. BURIAL REMOVAL (Specify)		22b. DATE THEREOF <u>2/15/1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Eden Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Rutland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frederick J. Bon</u> ADDRESS <u>Harold Chau</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 10 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kinn</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Handwritten text, possibly a list or notes, including the word "Handwritten" and other illegible characters.

Handwritten text, possibly a signature or date, including the word "Handwritten" and other illegible characters.

Handwritten text, possibly a signature or date, including the word "Handwritten" and other illegible characters.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2071

## CERTIFICATE OF DEATH

Reg. Dist. No.

02043

1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen</b>		c. LENGTH OF STAY IN lb <b>5 months</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Hospital Aberdeen Proving Ground, Md</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ALBERT</b> Middle <b>JOHN</b> Last <b>EYLES</b>		4. DATE OF DEATH Month <b>February</b> Day <b>8</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug 5, 1910</b>
9. AGE (In years lost birthday) yrs. <b>49</b>		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Soldier - Sic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>US Army</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
13. FATHER'S NAME <b>John Herman Eyles</b>		14. MOTHER'S MAIDEN NAME <b>Unknown - deceased</b>	
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW II</b>		16. SOCIAL SECURITY NO. <b>167-01-5712</b>	
17. INFORMANT <b>Official Army Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral anoxia</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <b>Hanging</b> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b> <b>unknown</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>Hanging</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>unknown</b> 19 <b>19</b> p. m. <b>unknown</b>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work <input checked="" type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Building 5227</b>		20f. (City or town) (County) (State) <b>Aberdeen Proving Ground, Md</b>	
21. I certify that I attended the deceased from <b>DOA Feb 8 1960</b> to <b>DOA</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>19</b> , and that death occurred at <b>5:10 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>United States Army Hospital</b> DATE SIGNED <b>8 Feb 60</b>			
ACTUAL SIGNATURE <b>Divo A Messori</b>		M.D. <b>United States Army Hospital</b> <b>8 Feb 60</b>	
PHYSICIAN'S NAME (Type) <b>DIVO A MESSORI Capt MC</b>		<b>Aberdeen Proving Ground, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>2-11-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Pittsburg, Pa.</b>		22d. LOCATION (City, town, or county) (State) <b>Pittsburg, Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook Blight Inc. 6009 Harford Rd.</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 11 '60</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Lewis</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2046

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02044

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Havre de Grace</b> 31 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Havre de Grace</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Fireworks Co.</b>		e. STREET ADDRESS <b>Ontario Street Extended</b>	
3. NAME OF DECEASED (Type or print) <b>James A. Fabrizio</b>		4. DATE OF DEATH <b>February 9 1960</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/27/1928</b>
9. AGE (In years last birthday) <b>31</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Owner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Fire Works Plant</b>	
11. BIRTHPLACE (State or foreign country) <b>Lancaster Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Achille Fabrizio</b>		14. MOTHER'S MAIDEN NAME <b>Algie Cimprosi</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Annita P. Fabrizio</b>		Address <b>Ontario St. Havre de Grace, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Third degree burns entire body</b> <b>9163</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fireworks Corp. Explosion</b>	
20c. TIME OF INJURY Month, Day, Year <b>2-9-60</b> 19		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Fireworks Corp.</b>		20f. (City or town) (County) (State) <b>Havre de Grace Harford Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Gerald C. Palmer</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> Bel Air, Md. DATE SIGNED <b>2-9-60</b>	
EXAMINER'S NAME (Type) <b>Gerald C. Palmer, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) <b>2/13/60</b>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion</b>		22d. LOCATION (City, town, or county) (State) <b>Havre de Grace Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur S. Thomas</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 17 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please excuse the delay in writing the certificate, writing the "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.



02145

2047

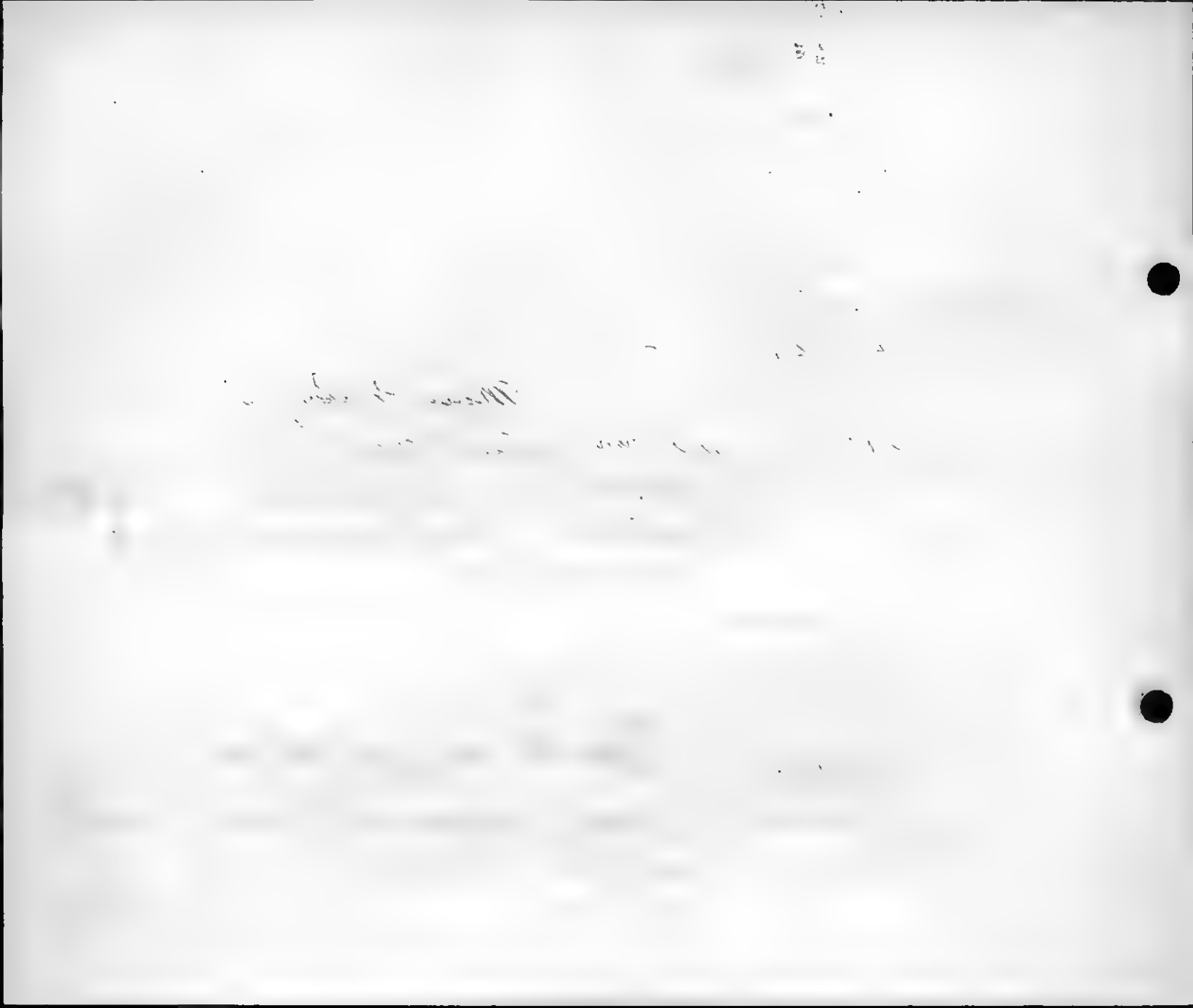
## CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>		c. LENGTH OF STAY IN 1b <u>30 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hartford Memorial Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>	
f. STREET ADDRESS <u>113 N Washington St</u>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>Minnie</u> Middle <u>Fresconi</u> Last <u></u>		4. DATE OF DEATH Month <u>2/4</u> Day <u>1960</u> Year <u>19</u>	
5 SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/16/1887</u>
9 AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min <u></u>	IF UNDER 24 HRS. Hours <u></u> Min <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	11 BIRTHPLACE (State or foreign country) <u>Italy</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Thomas Warick</u>		14. MOTHER'S MAIDEN NAME <u>Minnie Bresconi</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16 SOCIAL SECURITY NO. <u>Unknown</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular disease</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>0</u> m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f. (City or town) <u></u> (County) <u></u> (State) <u></u>
21. I certify that I attended the deceased from <u>Jan. 24th, 1960</u> to <u>Feb. 4th, 1960</u> that I last saw the deceased alive on <u>Feb. 4th, 1960</u> and that death occurred at <u>7:58 PM</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward C. Loo, M.D.</u>		ADDRESS (Street, city or town, state) <u>Harre-de-Grace, Md.</u> DATE SIGNED <u>2/5/60</u>	
PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/8/1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion</u>	22d. LOCATION (City, town, or county) (State) <u>Harre-de-Grace Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Pennington Rm. Harre-de-Grace, Md.</u>		24a. REC'D BY REGISTRAR <u></u> DATE <u>FEB 10 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur E. Thomas</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and show d be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 and 6 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 FOR STATE HEALTH DEPT

tem 18, Film 258  
-10-1-55  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2072 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 9, 15 Film 258 2-1-55 et

1. PLACE OF DEATH  
a. COUNTY **Harford** **MARYLAND**  
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Darlington**  
c. LENGTH OF STAY IN b **4Y 4M 1D**  
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) **Woods, Poole Rd. & US Rt. 1**

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)  
a. STATE **12 Pennsylvania**  
b. COUNTY **Philadelphia**  
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **2421 Pine St.**  
d. STREET ADDRESS **1**  
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print)  
First Middle Last  
**WILLIAM FRANCIS GOWEN, Jr.**

4. DATE OF DEATH  
Month Day Year  
**February 4 19 60**

5. SEX **Male** 6. COLOR OR RACE **White** 7. ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH **July 30, 1918** 9. AGE (In years last birthday) **41** 10. IF UNDER 1 YEAR Months Days Hours Min **12-1**

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Retired** 10b. KIND OF BUSINESS OR INDUSTRY **None** 11. BIRTHPLACE (State or foreign country) **Hoboken, N.J., U.S.A.** 12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13. FATHER'S NAME **Francis Gowen** 14. MOTHER'S MAIDEN NAME **Marguerite Horan**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) **Yes 10/14/41 - 6/17/42** 16. SOCIAL SECURITY NO. **10-17-42** 17. INFORMANT **Marguerite Gowen** Address **2421 Pine St. Philadelphia**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) **795.5** DUE TO **No Anatomical Cause of Death**  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) **None** DUE TO (c) **None**

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I **None**

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) **None**

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 **None** 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) **None** 20f. (City or town) (County) (State) **None**

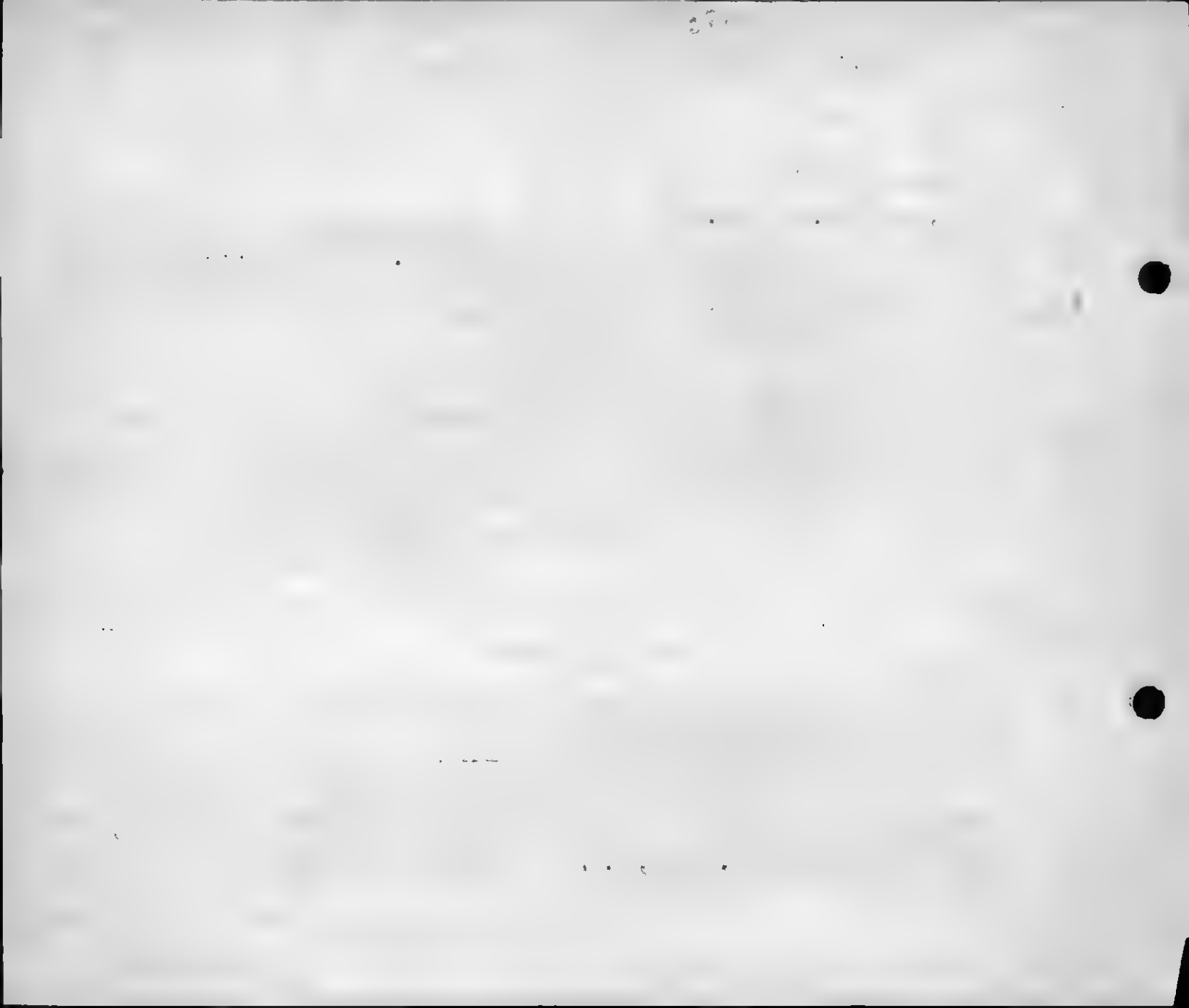
21 I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from. Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☒

ACTUAL SIGNATURE **Charles S. Petty, M.D.** M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ DEPUTY MEDICAL EXAMINER ☐ DATE SIGNED **2/5/60**

EXAMINER'S NAME (Type) **Charles S. Petty, M.D.** Address (Street, city, town, or county) **None**

22a. BURIAL, CREMATION, or REMOVAL (Specify) **Feb 10, 1960 St. Roman Church Ardmore, Pa** 22b. DATE THEREOF **Feb 10, 1960** 22c. NAME OF CEMETERY OR CREMATORY **St. Roman Church** 22d. LOCATION (City, town, or county) (State) **Ardmore, Pa**

23. FUNERAL DIRECTOR **A.S. Bailey** ADDRESS **Darlington, Md** 24a. REC'D BY REG STRAR **FEB 9 '60** 24b. REGISTRAR'S SIGNATURE **Charles S. Petty**



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2043

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 9 Baltimore 2-23-60 et

Reg. Dist. No.

02047

1. PLACE OF DEATH a. COUNTY <b>Harford</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Harre de Grace</b>		c. LENGTH OF STAY IN 1b <b>5 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Harford Memorial Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Forest Hill</b>	
3. NAME OF DECEASED (Type or print) <b>George Elwood Gunther</b> First Middle Last		f. STREET ADDRESS <b>Grier's Nursery Road</b>	
4. DATE OF DEATH Feb. 14 19 60 Month Day Year		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov 1-1894</b>
9. AGE (In years last birthday) <b>65 64</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TREE Surgeon</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Tree Trimmer</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore Co Md</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>William H Gunther</b>		14. MOTHER'S MAIDEN NAME <b>Martha Townsley</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>218-10-2295</b>	
17. INFORMANT <b>MRS. Ethel G Gunther</b>		Address <b>Forest Hill, Md. RD</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Comminuted fracture femur</b> <b>902.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH? <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell out of tree he was trimming</b>	
20c. TIME OF INJURY Month, Day, Year <b>10</b> Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input checked="" type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Farm</b>		20f. (City or town) (County) (State) <b>Forest Hill Harford Md.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Gerald C Palmer</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> Bel Air, Md.	
EXAMINER'S NAME (Type) <b>Gerald C. Palmer M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> 2-14-60	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Feb 17-1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Zion Greek Methodist</b>	22d. LOCATION (City, town, or county) (State) <b>Chestnut Hill Harford Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph J. Foster Bel Air, Md.</b>		24a. REC'D BY REGISTRAR <b>FEB 16 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Christina S. Thomas</b>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File with the registrar prior to burial, cremation, or removal.



## 2073 CERTIFICATE OF DEATH

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Harford</u> MARYLAND		<b>2. USUAL RESIDENCE</b> (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BEL AIR RURAL</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BEL AIR</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford County Convalescent Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Bertha M. Hall</u>		<b>4. DATE OF DEATH</b> Month Day Year <u>February 20, 1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 10, 1879</u>
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS:	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	
11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ISAAC N. HALL</u>		14. MOTHER'S MAIDEN NAME <u>ANNA E. Camby</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Edward N. Hall</u>		Address <u>Hickory Ave., BEL AIR, Md.</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>TOXEMIA INCIDENT TO GANGRENE OF SACRAL AREA (VASCULAR THROMBOSIS)</u> (b) <u>Ch. CARDIO-VASCULAR DISEASE</u> (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>5da</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 1955</u> to <u>Feb 20, 1960</u> , that I last saw the deceased alive on <u>Feb 19, 1960</u> , and that death occurred at <u>1:15 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>W. Clarence P. Hudson M.D.</u>			
PHYSICIAN'S NAME (Type) _____			
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 22, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Methodist Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Fountain Green (Bel Air Rd) Harford Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph W. Foster</u>		ADDRESS <u>W. Broadway &amp; Williams St. BEL AIR, Maryland</u>	
24a. REC'D BY REGISTRAR DATE <u>FEB 24 '60</u>		24b. REGISTRAR'S SIGNATURE <u>C. L. &amp; K. K.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



02043

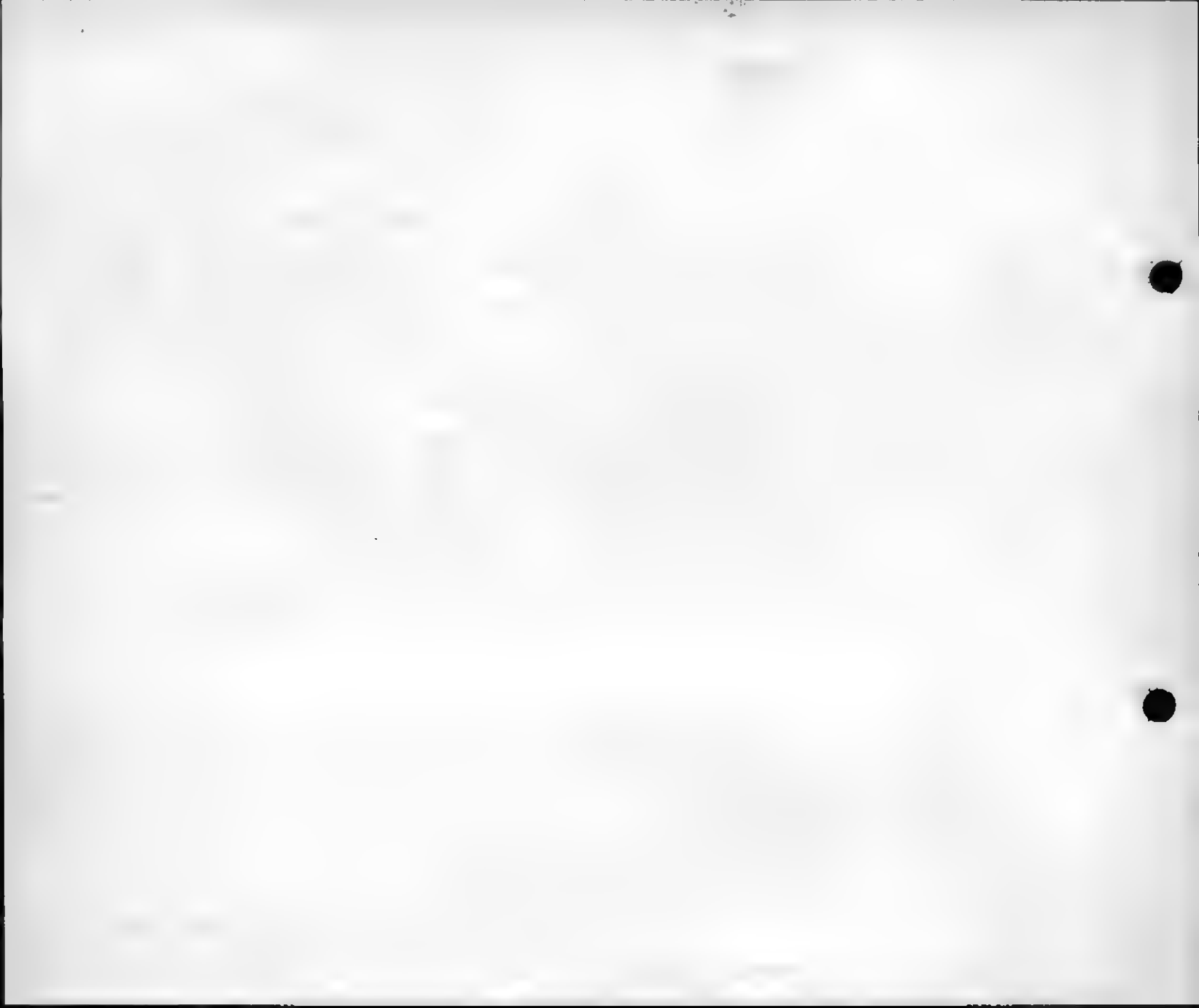
## CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <i>Hartford</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a STATE <i>MD</i> b COUNTY <i>Hartford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hartford</i>		c. LENGTH OF STAY IN 1b <i>46 min</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Hartford Memorial Hospital</i>		e. STREET ADDRESS <i>Chesnut Hill</i>	
3. NAME OF DECEASED (Type or print) <i>HELEN R. HARKINS</i>		4. DATE OF DEATH Month <i>2</i> Day <i>8</i> Year <i>1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>MAY 11, 1895</i>
9. AGE (In years last birthday) <i>64</i> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	
11. BIRTHPLACE (State or foreign country) <i>BALTO. CO., MD.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>J. WATKIN RITTER</i>		14. MOTHER'S MAIDEN NAME <i>MARY M. BURGAN</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>—</i>	
17. INFORMANT <i>MRS. HARRY TOWNSLEY, BELAIR, MD.</i>		Address <i>—</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Acute cardiac decompensation</i> DUE TO <i>Coronary thrombosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>A. S. C. V. D.</i> DUE TO <i>—</i> (c) <i>—</i>			INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>—</i>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <i>—</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>—</i> p. m. <i>—</i> 19 <i>60</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>2/8-11-1960</i> to <i>2/25-1960</i> that I last saw the deceased alive on <i>2/8-11-1960</i> , and that death occurred at <i>8:40 PM</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>—</i> M.D.		DATE SIGNED <i>2/8/60</i>	
PHYSICIAN'S NAME (Type) <i>—</i>		ADDRESS (Street, city or town, state) <i>—</i>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>FEB 14 1960</i>	22c. NAME OF CEMETERY OR CREMATORY <i>WATKINSVILLE CEM.</i>	22d. LOCATION (City, town, or county) (State) <i>WATKINSVILLE MD.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John H. Jenkins, Belts, Pa.</i>		24a. REC'D BY REGISTRAR DATE <i>FEB 11 '60</i>	
ADDRESS <i>—</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2050

## CERTIFICATE OF DEATH

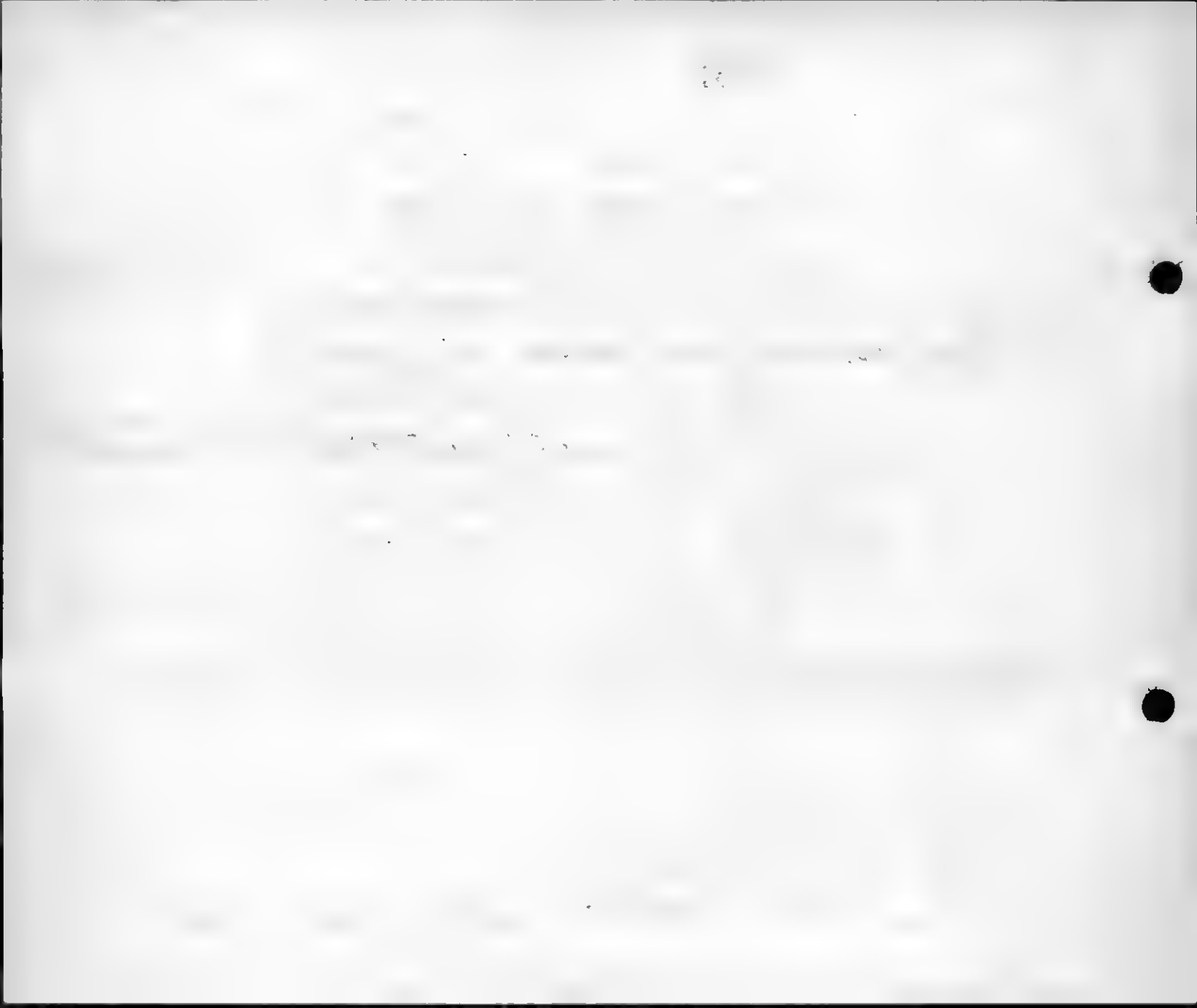
Reg. Dist. No.

02050

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAURE DE GRACE</b> c. LENGTH OF STAY IN 1b <b>50 Min.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INST. TUTION <b>HARFORD MEMORIAL Hosp.</b>		2. USUAL RESIDENCE (Where deceased lived, If institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>HARFORD</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EDGEWOOD</b> d. STREET ADDRESS <b>34 Brown St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>William Henry Hawthorne</b>		4. DATE OF DEATH <b>February 6 1960</b>		5. SEX <b>MALE</b>	
6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 30 1909</b>	
9. AGE (In years last birthday) <b>50 yrs</b>		10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>1st Lieutenant Army Chemical</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MARYLAND</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>William Hawthorne</b>		14. MOTHER'S MAIDEN NAME <b>HARRIETTE JONES</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO <b>212-26-3027</b>		INFORMANT <b>Elizabeth Hawthorne Edgewood Md</b>	
17. ADDRESS <b>34 Brown St</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>146X METASTATIC CARCINOMA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CARCINOMA OF NASOPHARYNX</b> (c) <b>(Original site)</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <b>May 1</b> , 1957, to <b>Feb 6</b> , 1960, that I last saw the deceased alive on <b>Feb 6</b> , 1960, and that death occurred at <b>3:00</b> M, from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>Willard P. Hudson</b>		ADDRESS (Street, city or town, state) <b>Forest Tree, Md</b>		DATE SIGNED <b>2/6/60</b>	
PHYSICIAN'S NAME (Type)					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial Feb 9 1960</b>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <b>Wm. Watson Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Cooperstown Harford Md</b>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles C. Kurtz</b>		ADDRESS <b>Garrettsville Md</b>		24a. REC'D BY REGISTRAR <b>DATE FEB 9 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film 9258 3-14-60 et

2051

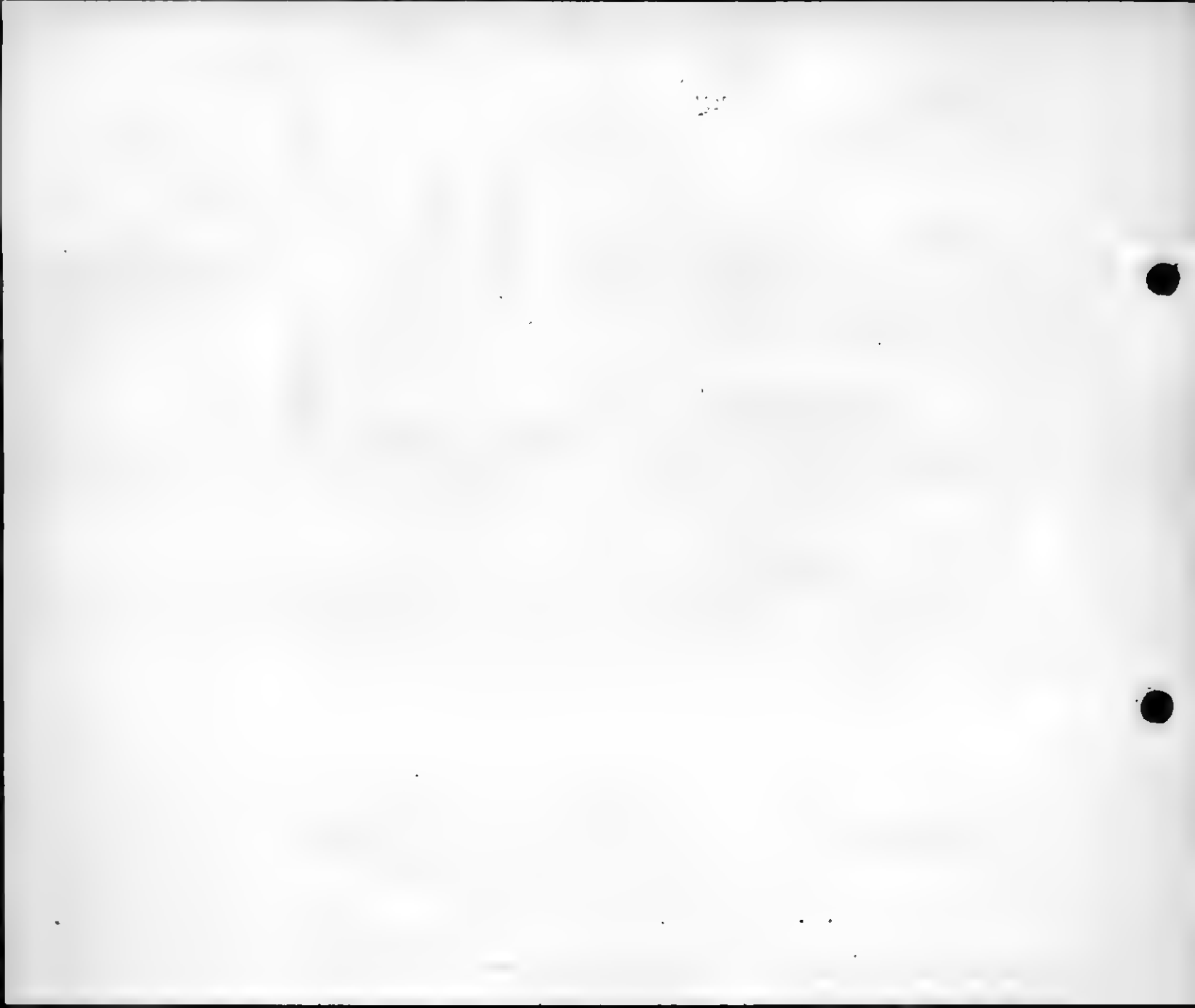
## CERTIFICATE OF DEATH

Reg. Dist. No.

02051

1. PLACE OF DEATH a. COUNTY <u>Harford</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u> c. LENGTH OF STAY IN lb <u>7 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u> d. STREET ADDRESS <u>Box 166, #2, Bel Air, Harford Co., Md.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Elmer</u> Middle <u>Thomas</u> Last <u>Hinkle</u>		4. DATE OF DEATH Month <u>February</u> Day <u>29</u> Year <u>1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-23-81</u>
9. AGE (In years last birthday) <u>78</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>	11. BIRTHPLACE (State or foreign country) <u>Virginia</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>		13. FATHER'S NAME <u>John Williams Hinkle</u>	
14. MOTHER'S MAIDEN NAME <u>Ruth Ann Moutz</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO <u>Thomas E Hinkle (son)</u>		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myelodysplasia, acute &amp; chronic</u> <u>600.</u> DUE TO (b) <u>Ca of bladder</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>Bronchopneumonia bilateral</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <input type="checkbox"/>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Feb 20</u> , 19 <u>60</u> , to <u>Feb 29</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>February 29</u> , 19 <u>60</u> , and that death occurred at <u>11:00 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Erinda L. Garbella, M.D.</u>			
PHYSICIAN'S NAME (Type) <u>ERINDA L. GARBELLA, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3.3.60</u>	22c. NAME OF CEMETERY OR CREMATOR <u>Tonoloway Baptist</u>	22d. LOCATION (City, town, or county) (State) <u>Hancock Washington Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard J. Moore Hancock md</u>		24a. REC'D BY REGISTRAR <u>MAR 7 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraw</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Pages 1 and 2 should be filled with the attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



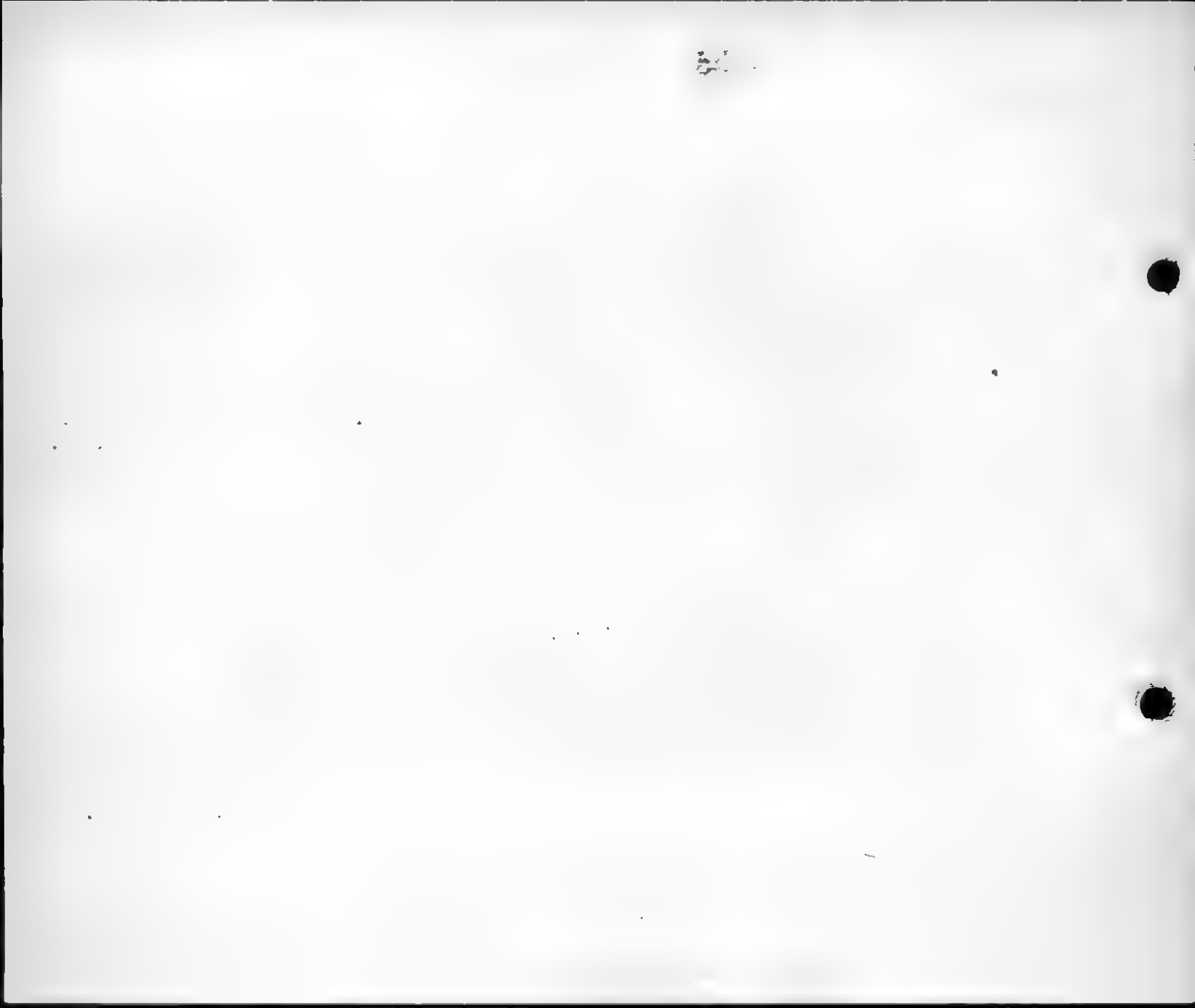
2052

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Id</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>BABY</u> Middle <u>JOY</u> Last <u>Johnson</u>		4. DATE OF DEATH Month <u>February</u> Day <u>14</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u> Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 14, 1960</u>
9. AGE (In years last birthday) yrs. <u>6</u>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>DOROTHY LORETTA JOHNSON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>INFORMANT Dorothy L. Johnson Address 13 Fenway Court Mother Aberdeen, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atelectasis</u> 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Prematurity</u>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2/14</u> , 19 <u>60</u> , to <u>2/14</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>2/14</u> , 19 <u>60</u> , and that death occurred at <u>4:14</u> PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>569 Revolution St. Harford, Md.</u> DATE SIGNED <u>2/14/60</u>			
ACTUAL SIGNATURE <u>George T. Stansbury</u>		M.D. <u>569 Revolution St. Harford, Md.</u>	
PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>cremation</u>	22b. DATE THEREOF <u>2-14-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>HARFORD MEMORIAL HOSPITAL</u>	22d. LOCATION (City, town, or county) (State) <u>Harford, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry R. Ziegler</u> ADDRESS <u>Administrator</u>		24a. REC'D BY REGISTRAR <u>FEB 26 '60</u>	24b. REGISTRAR'S SIGNATURE <u>William L. Farris</u>

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2074

## CERTIFICATE OF DEATH

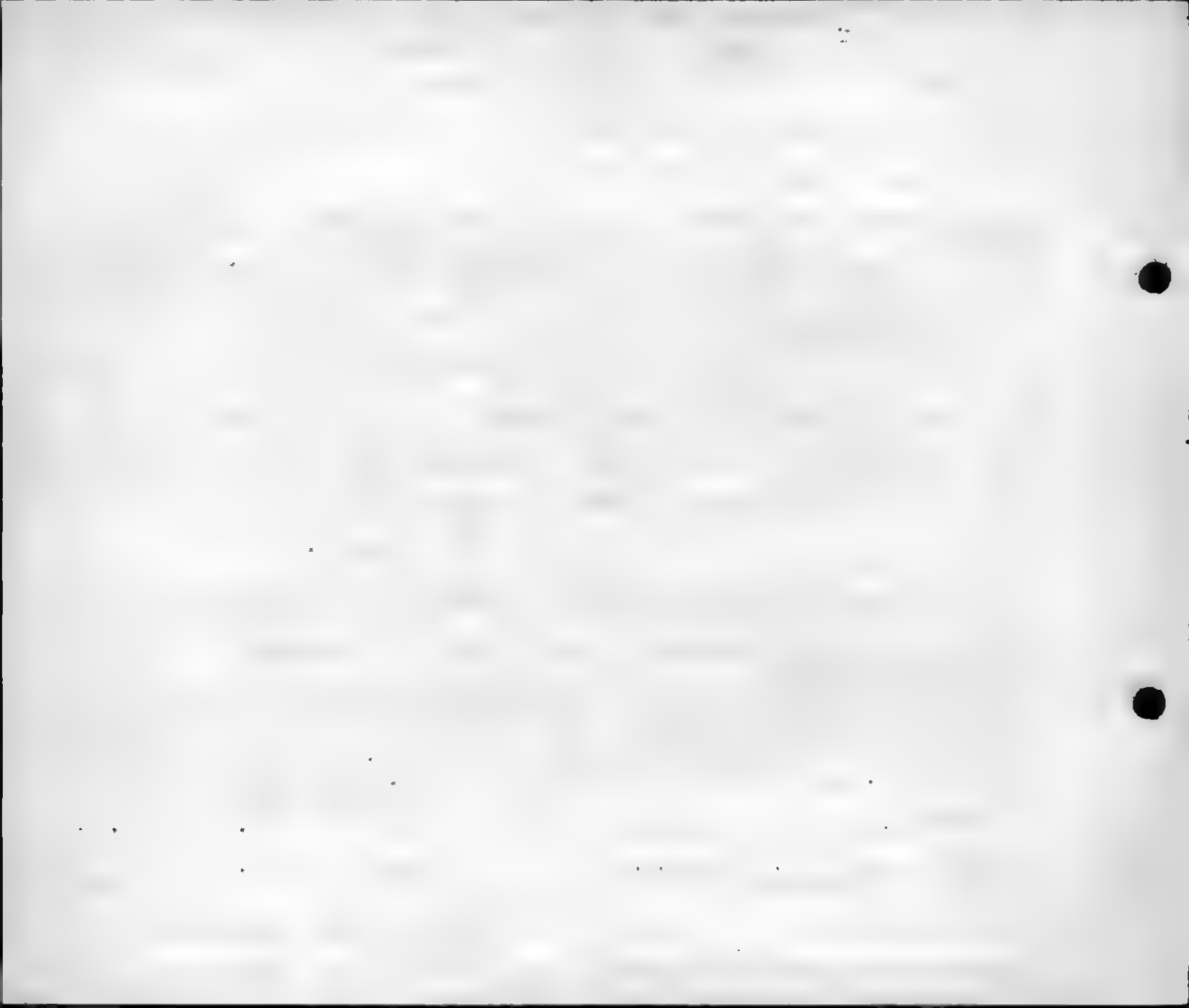
02052

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel-air Rk.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel-air Rk.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lottie Johnson</u>		4. DATE OF DEATH Month Day Year <u>Feb. 4, 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. <del>MARRIED</del> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1883</u>
9. AGE (in years last birthday) <u>76</u> yrs		IF UNDER 1 YEAR: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife at home</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Harford Co Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Jannie Lutton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Roosevelt Johnson</u>		Address <u>Harford Co, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Cardio Vascular Disease.</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>  <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. ft. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June</u> , 19 <u>40</u> , to <u>Feb. 4</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Feb. 3</u> , 19 <u>60</u> , and that death occurred at <u>4:00 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Willard P. Hudson</u> M.D. <u>Forest Hill, Md.</u> <u>Feb. 4, 1960</u>			
PHYSICIAN'S NAME (Type) <u>Willard P. Hudson M.D.</u> <u>Forest Hill, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
	<u>Feb. 7, 1960</u>	<u>Clark Chapel Cn.</u>	<u>Harford Co. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Bailey</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 9 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

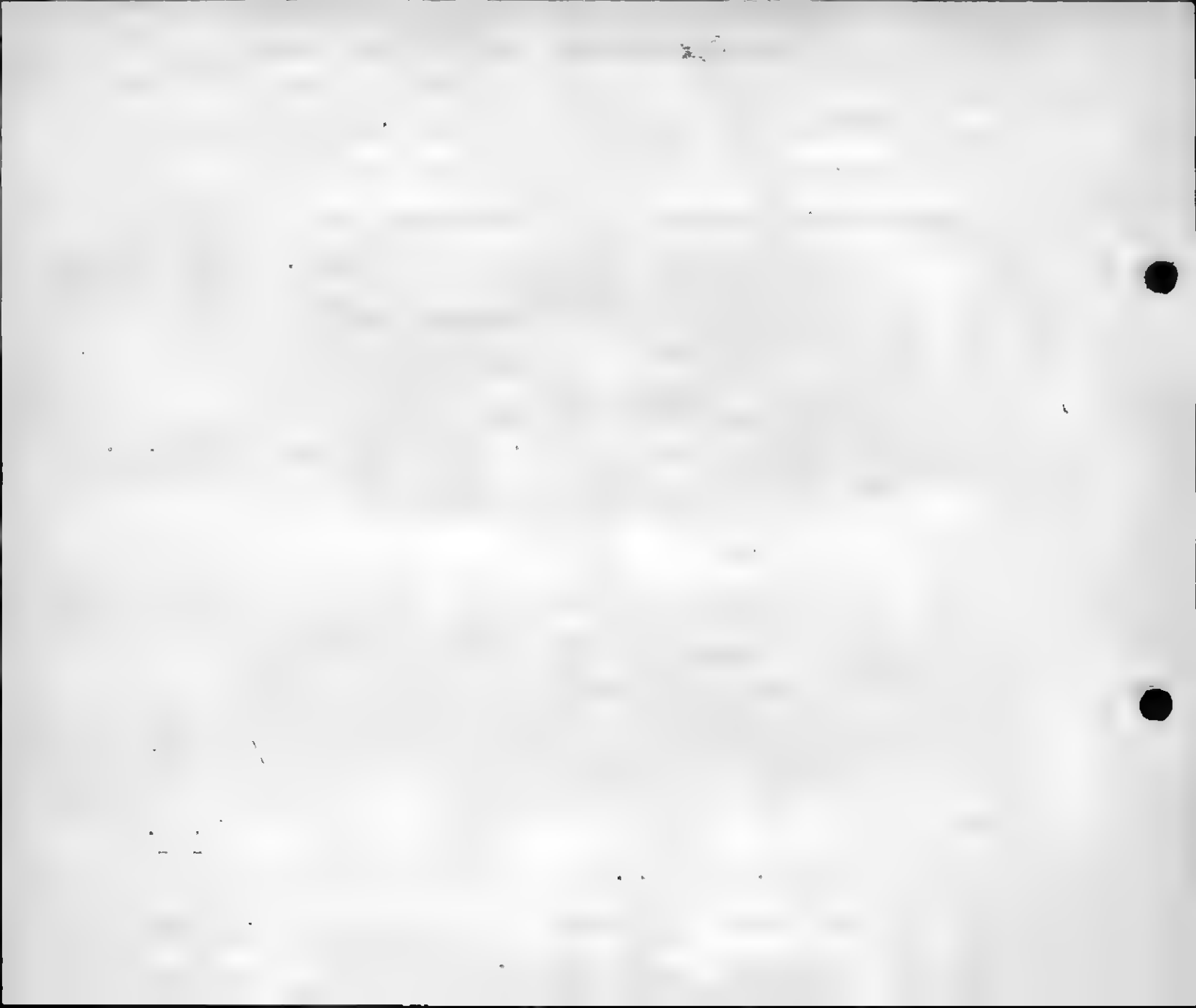
02054

2075

1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Harford</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural- Street</b>				c. LENGTH OF STAY IN 1b <b>10 years</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Farm Paul McNabb</b>				d. STREET ADDRESS <b>Farm of Paul McNabb</b>			
3. NAME OF DECEASED (Type or print) First <b>Walter</b> Middle <b>Keeney</b> Last				4. DATE OF DEATH Month <b>Feb.</b> Day <b>14</b> Year <b>19 60</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 14, 1892</b>		9. AGE (In years last birthday) <b>67 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dairy</b>		11. BIRTHPLACE (State or foreign country) <b>York Co., Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mrs. Walter Keeney, Whiteford, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic C V Disease</b> <b>420.</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Gerald C Palmer</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> Bel Air, Md. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Gerald C. Palmer M.D.</b>				DATE SIGNED <b>2-14-60</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-17-1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Slate Ridge</b>		22d. LOCATION (City, town, or county) (State) <b>Delta, Penna.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John H. Harbison</b>				ADDRESS <b>Delta, Penna.</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 17 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Harbison</b>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

Item 9 Film 4256 2-16-60 et

2053

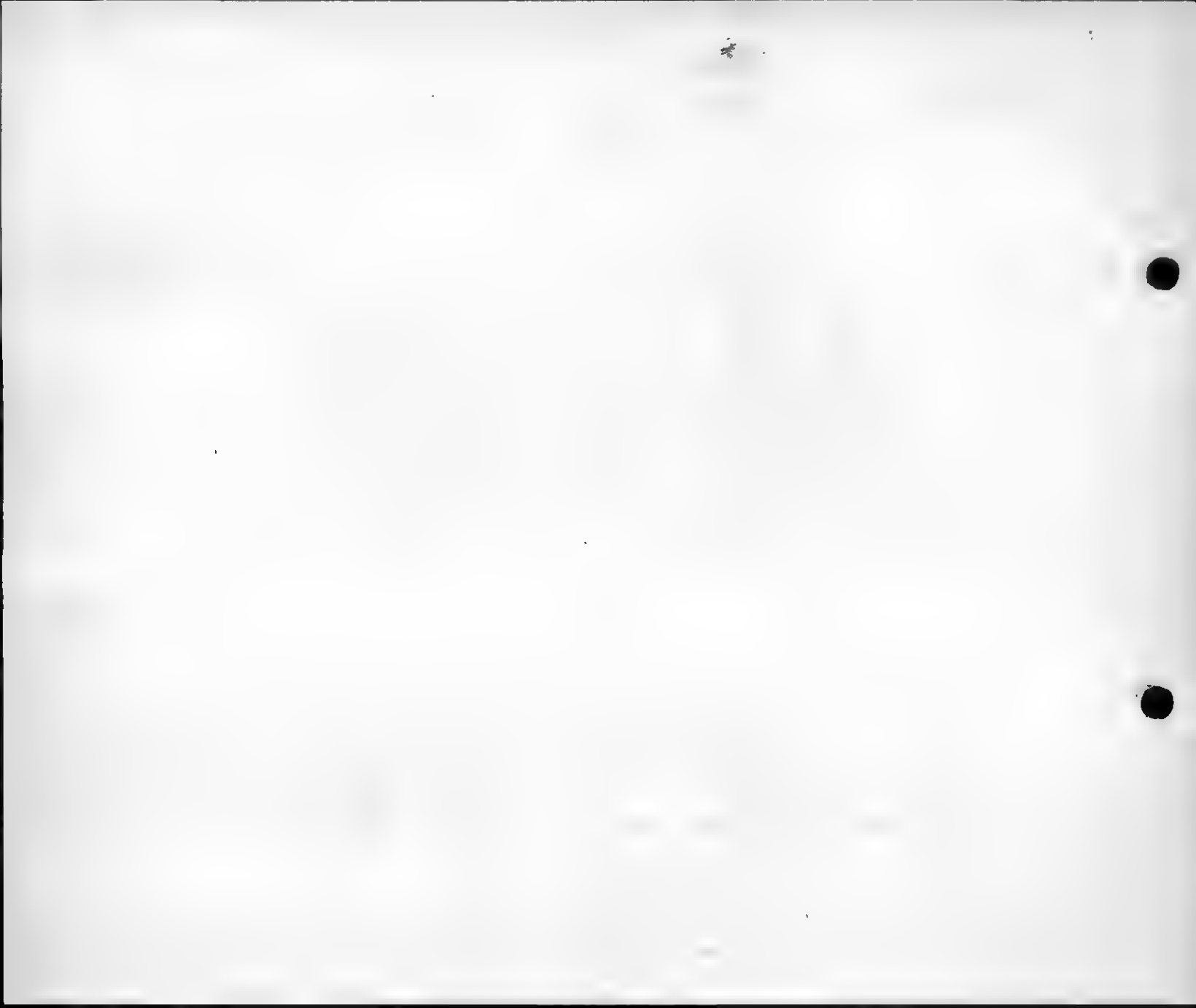
## CERTIFICATE OF DEATH

02055

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAURE DE GRACE</b> c. LENGTH OF STAY IN 1b <b>24 YRS.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>—</b>		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>HARFORD.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAURE DE GRACE.</b> d. STREET ADDRESS <b>662 FRANKLIN ST.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>HOUSE</b> Middle <b>M.</b> Last <b>KELLY</b>		4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>6</b> Year <b>1960.</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 6, 1881</b>
9. AGE (in years last birthday) <b>78</b> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <b>—</b> Days <b>—</b> Hours <b>—</b> Min. <b>—</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NONE.</b>	
11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	
13. FATHER'S NAME <b>PATRICK DABBY</b>		14. MOTHER'S MAIDEN NAME <b>MARIA KEIFFER.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>—</b>		16. SOCIAL SECURITY NO. <b>UNKNOWN</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY THROMBOSIS</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO (c) <b>—</b>		INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>GENERALIZED ARTERIOSCLEROSIS</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>—</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>FEB 6</b> , 19 <b>60</b> , to <b>FEB 6</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>FEB. 6</b> , 19 <b>60</b> , and that death occurred at <b>2:03 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>662 FRANKLIN ST. HARFORD, MD.</b> DATE SIGNED <b>2-6-60</b> ACTUAL SIGNATURE <b>Raymond J. Donovan, Jr.</b> M.D. <b>FEB 6 1960</b> PHYSICIAN'S NAME (Type) <b>Raymond J. Donovan, Jr.</b>			
22. BURIAL, CREMATION, REMOVAL (Specify) <b>2/10/60</b>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <b>Charles Barker</b>		22d. LOCATION (City, town, or county) (State) <b>Centerville Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Frederick M. Henschel</b> ADDRESS <b>Harford, Md.</b>		24a. REC'D BY REGISTRAR <b>—</b> DATE <b>FEB 10 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2054

## CERTIFICATE OF DEATH

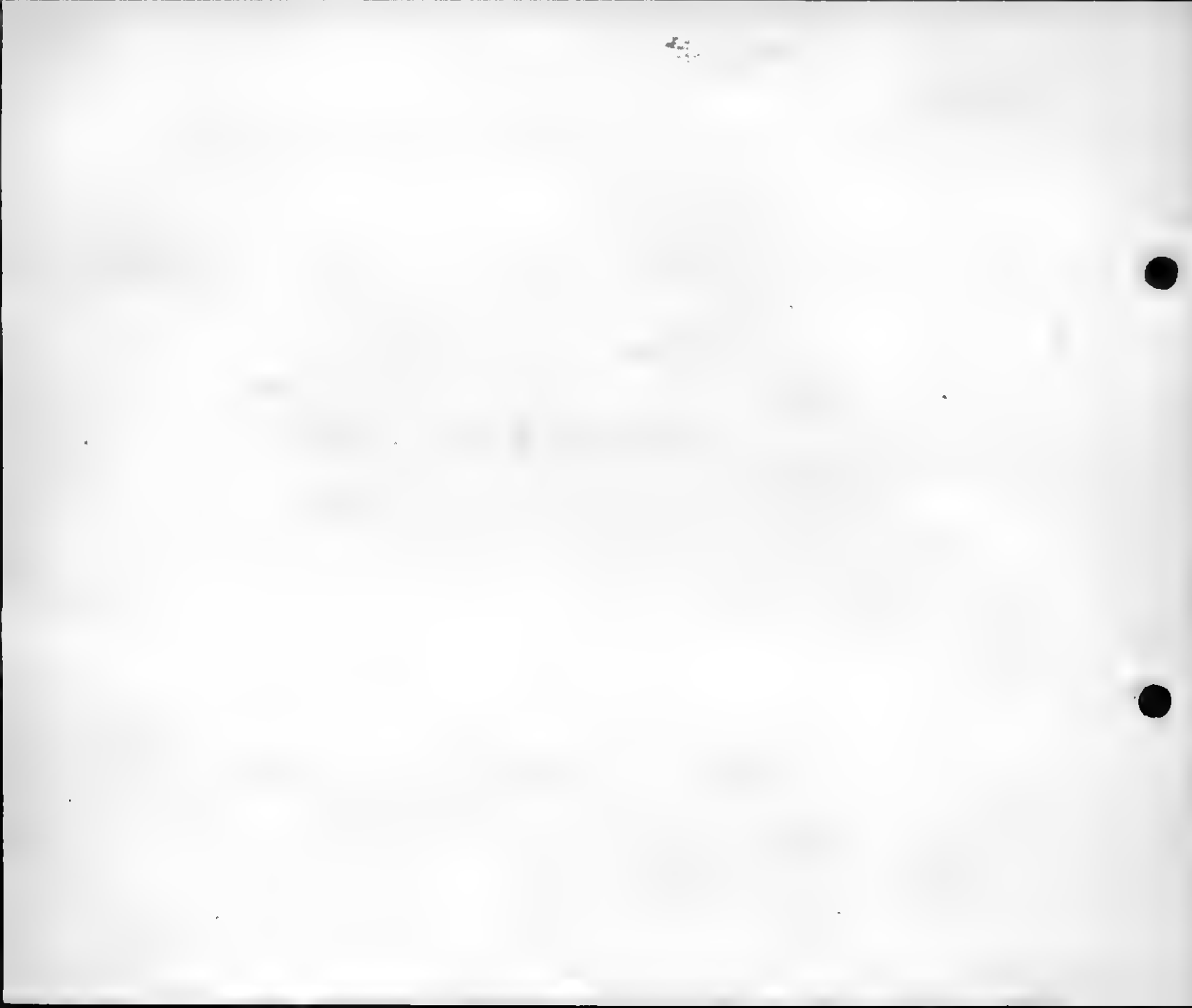
Reg. Dist. No.

02056

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAUBERT GRACE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port Deposit, Rural</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL HOSPITAL</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Jacob Guy Kirk</u>		4. DATE OF DEATH Month Day Year <u>Feb 1 1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 10, 1880</u>
9. AGE (In years last birthday) yrs. <u>79</u>		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Owner</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>E. Allen Kirk</u>	
14. MOTHER'S MAIDEN NAME <u>Mary Agness Aikin</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>217-36-2912</u>		INFORMANT Address <u>Miss Mary R. Kirk, Port Deposit, Md. R F D</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>464 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) <u>Thrombophlebitis &amp; cerebral emboli</u>		INTERVAL BETWEEN ONSET AND DEATH <u>30 min.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on <u>February 1, 1960</u> , and that death occurred at <u>10:45</u> AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Neil Taylor</u> M.D.		ADDRESS (Street, city or town, state) <u>Rising Sun, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Neil Taylor</u>		DATE SIGNED <u>2/1/60</u>	
22a. BURIAL CREMATION, REINTERMENT (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-4-1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>West Nottingham</u>		22d. LOCATION (City, town, or county) (State) <u>Colona, Md. Rural</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee A. Catteras</u>		ADDRESS <u>Perryville, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>FEB 4 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoms</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2055 CERTIFICATE OF DEATH

02057

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>	
c. LENGTH OF STAY IN 1b <u>2 days + 9 1/2</u>		d. STREET ADDRESS <u>314 Wilson</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Blanche Regina LANE</u>		4. DATE OF DEATH Month Day Year <u>February 28 1960</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 25 1960</u>
9. AGE (In years last birthday) yrs. <u>2</u>		10. IF UNDER 1 YEAR Months Days Hours Min <u>2</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Alfred Lane</u>		14. MOTHER'S MAIDEN NAME <u>Marie Miller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Alfred Lane</u>		18. ADDRESS <u>314 Wilson St, Harford, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cor. the Heart Failure</u> <u>754.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Intermittent Atrial Fibril</u> DUE TO (c) <u>Intermittent Atrial Fibril</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 25 1960</u> to <u>Feb 28 1960</u> that I last saw the deceased alive on <u>Feb 28 1960</u> , and that death occurred at <u>4:45 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Erinda L. Marbella</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>ERLINDA L. MARBELLA, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>2/29/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Angel Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Harford, MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Don Harford</u>		24a. REC'D BY REGISTRAR <u>MAR 2 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2076 CERTIFICATE OF DEATH

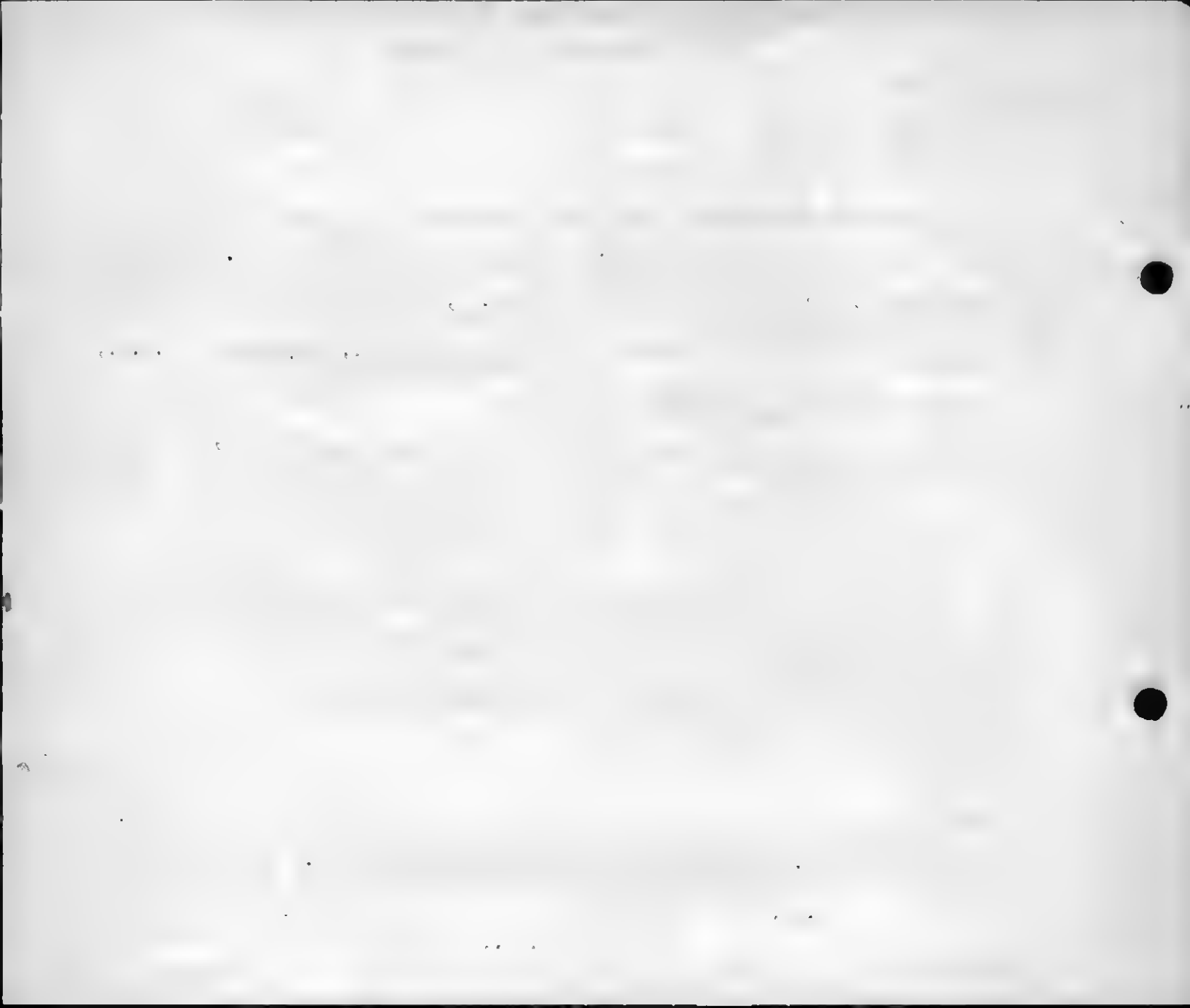
02058

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Abingdon</u>				c. LENGTH OF STAY IN Tn <u>Lifetime</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Bertha</u> Middle <u>E.</u> Last <u>Lee</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>24</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 20, 1887</u>		9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Harford Co., Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Parker</u>				14. MOTHER'S MAIDEN NAME <u>Martha Bishop</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Type, no or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Ellsworth Lee</u>		Address <u>Abingdon, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>o. m.</u> Month <u>11</u> Day <u>12</u> Year <u>1959</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/12</u> , 19 <u>59</u> , to <u>2/24</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>2/23</u> , 19 <u>60</u> , and that death occurred at <u>8:30 p. m.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>569 Revolution St., Havre de Grace, Md.</u> DATE SIGNED <u>2/26/60</u>							
ACTUAL SIGNATURE <u>George T. Stansbury</u>		M.D. <u>569 Revolution St., Havre de Grace, Md.</u>					
PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>		<u>569 Revolution St., Havre de Grace, Md.,</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 27, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>John Wesley</u>		22d. LOCATION (City, town, or county) (State) <u>Abingdon, Harford, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. McNamee</u>				ADDRESS <u>Abingdon, Md.,</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 1 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Cynthia S. Thomas</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2039 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02053

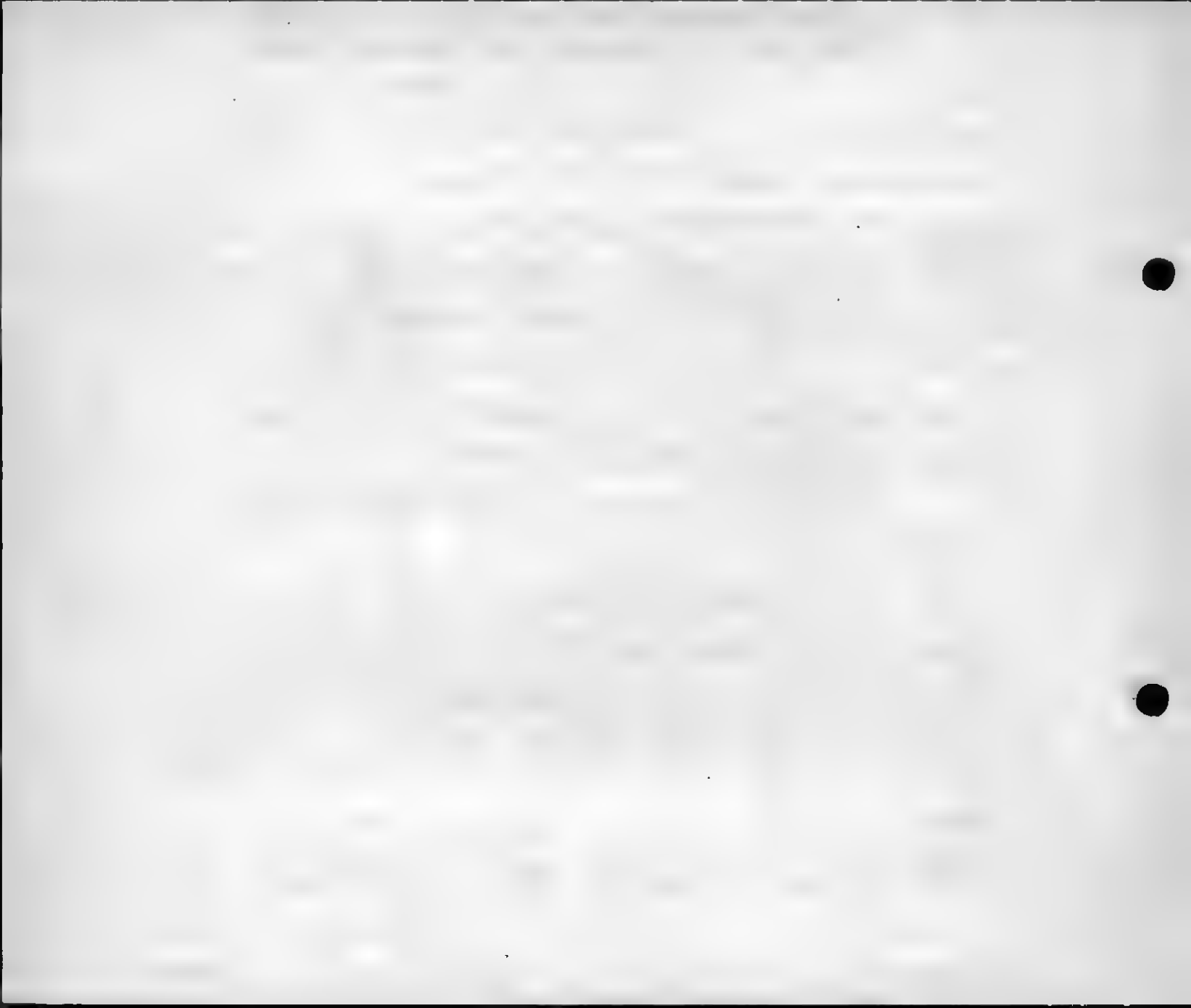
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>		c. LENGTH OF STAY IN 1b <u>7 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>32 Bel Air</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Ridgewood Road</u>				1d. STREET ADDRESS <u>Ridgewood Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Ann</u> Last <u>Linetty</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>25</u> Year <u>1960</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-29-95</u>	9. AGE (In years last birthday) <u>61</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Presser</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Clothing Manufacture</u>		11. BIRTHPLACE (State or foreign country) <u>Austria</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Washko</u>				14. MOTHER'S MAIDEN NAME <u>Helen Wargo</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>203-20-7993</u>		17. INFORMANT <u>Mr. Barney Linetty</u> Address <u>721 Ridgewood Road, Bel Air, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cerebrovascular Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>  </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Gerold C Palmer</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Gerold C Palmer</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 29, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>		22d. LOCATION (City, town, or county) (State) <u>Bel Air, Harford County, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph W. Fater</u> ADDRESS <u>W. Broadway + Williams St. Bel Air, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 29 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.



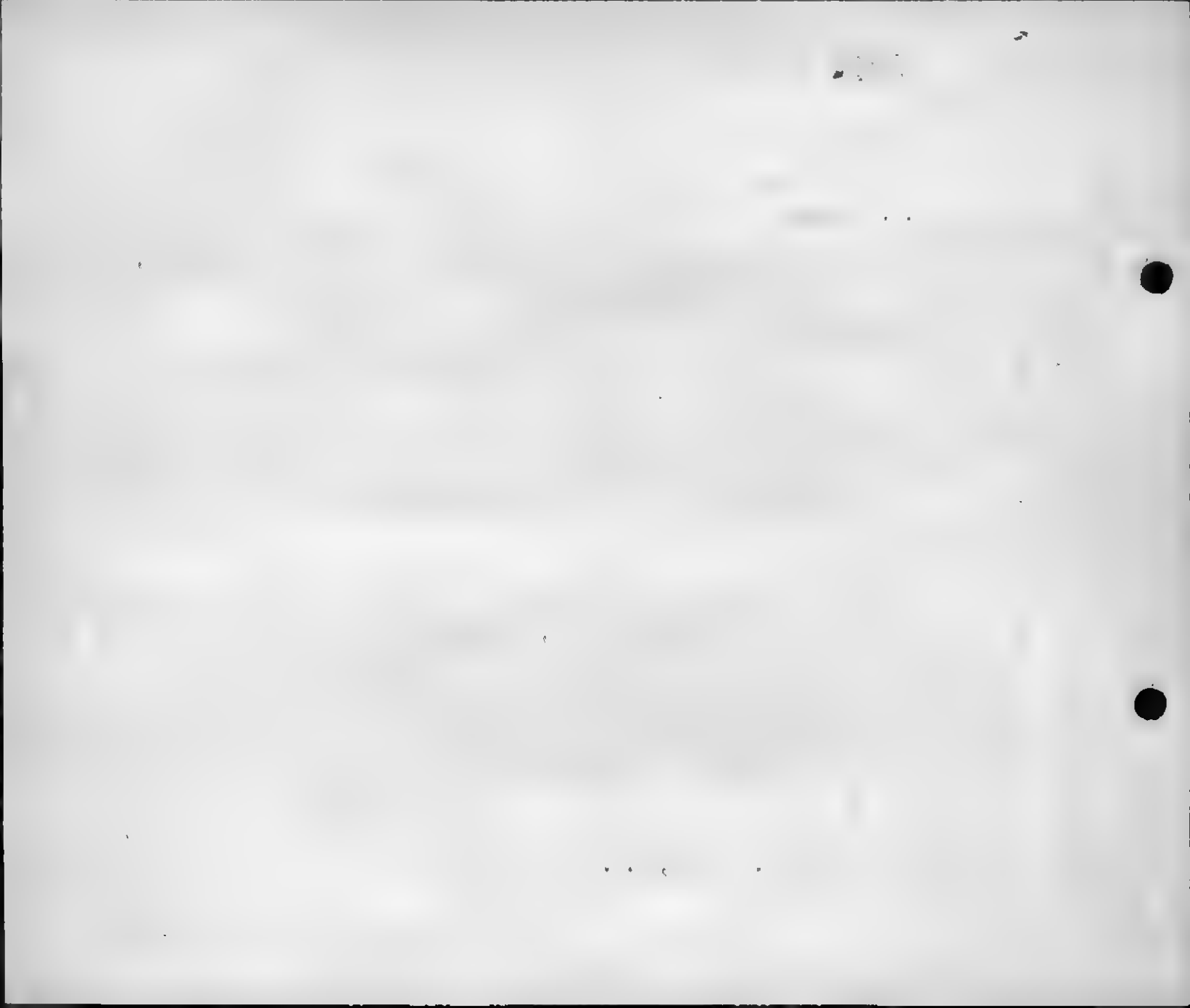
1#  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

2077 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Harford</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Abingdon</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Aberdeen</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U.S. Route 40</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>STROMAN</b>		4. DATE OF DEATH <b>February 13, 1960</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>	
7. MARIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 8, 1917</b>		9. AGE (In years last birthday) <b>42</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>	
11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>John Macdon</b>		14. MOTHER'S MAIDEN NAME <b>Lillian Anderson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no.</b>		16. SOCIAL SECURITY NO. <b>130-01-0005</b>		17. INFORMANT <b>Mrs. Ada Macdon, Aberdeen, Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Polycystic kidneys, bilaterally</b>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <b>R. S. Fisher</b>		EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>2/15/60</b>	
22a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-17-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Union Methodist Cem.</b>		22d. LOCATION (City, town, or country) (State) <b>Aberdeen Md.</b>	
23. FUNERAL DIRECTOR <b>Ottis J. Bullock, Shore de Grace, Md.</b>		ADDRESS <b>556 Lewis St.</b>		24a. REC'D BY REGISTRAR <b>FEB 17 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kneass</b>	



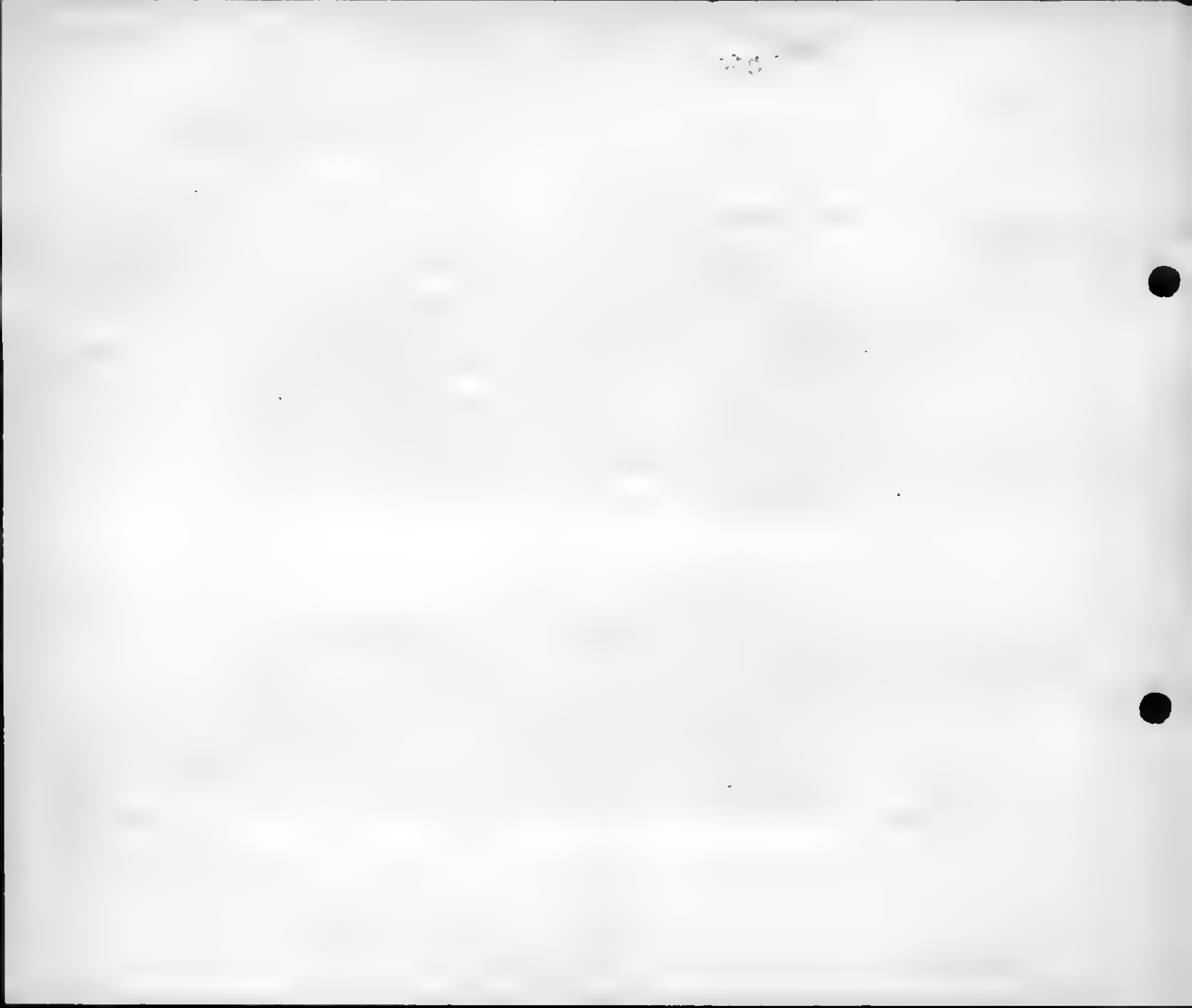
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

2056

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02061

1. PLACE OF DEATH a. COUNTY <u>Harford</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>				c. LENGTH OF STAY IN 1b <u>20 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>517 So. Stokes Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Miller</u> Last <u>Miller</u>				4. DATE OF DEATH Month <u>2</u> Day <u>8</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 3, 1875</u>	
9. AGE (In years lost birthday) <u>84 yrs</u>		10. IF UNDER 1 YEAR Months <u>8</u> Days <u>4</u> Hours <u>0</u> Min <u>0</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>City Worker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>street repair city</u>			
13. FATHER'S NAME <u>No Record</u>				14. MOTHER'S MAIDEN NAME <u>No Record</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>218-12-2917</u>		17. INFORMANT <u>Mrs. Lois Byrd, Harre de Grace, Md.</u> Address <u>519 So Stokes St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardio renal disease</u> (c) <u>Hypertensive Cardio renal disease</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11/4</u> 19 <u>57</u> to <u>2/8</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>2/7</u> 19 <u>60</u> , and that death occurred at <u>5:50 A.M.</u> from the causes and on the date stated above							
22a. SIGNATURE <u>George T. Stansbury</u>				22b. DATE SIGNED <u>2/10/60</u>			
22c. PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>				22d. ADDRESS <u>569 Revolution St. Harre de Grace, Md</u>			
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-11-1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Burke Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Washington, Harford Co, Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur J. Bullock, Harre de Grace, Md.</u>				25a. REC'D BY REGISTRAR <u>DATE FEB 15 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur J. Bullock</u>	



VS. AISME  
5M 7/59

## 02062

1. PLACE OF DEATH  
a. COUNTY **Harford** MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Edgewood**

c. LENGTH OF STAY IN b. **3 1/2**

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)  
a. STATE **Maryland** b. COUNTY **Harford**

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Edgewood**

d. STREET ADDRESS **1**

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Middle Last **CHRISTOPHER COLUMBUS MYERS**

4. DATE OF DEATH Month Day Year **February 14, 1960**

5. SEX **Male**

6. COLOR OR RACE **White**

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH **07-19-11**

9. AGE (In years last birthday) **48** yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Mins.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Contracting**

10b. KIND OF BUSINESS OR INDUSTRY **Pittsford, N.Y.**

11. BIRTHPLACE (State or foreign country) **U.S.**

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME **Christopher Columbus Myers**

14. MOTHER'S MAIDEN NAME **Sarah Myers**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) **No**

16. SOCIAL SECURITY NO. **226-09-6373**

17. INFORMANT **Mrs. C.C. Myers, Joppatowne, Md.** Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) **Arteriosclerotic cardiovascular disease**  
4 1 DUE TO  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c)  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 **While at work** 20d. INJURY OCCURRED **Not While at work** 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

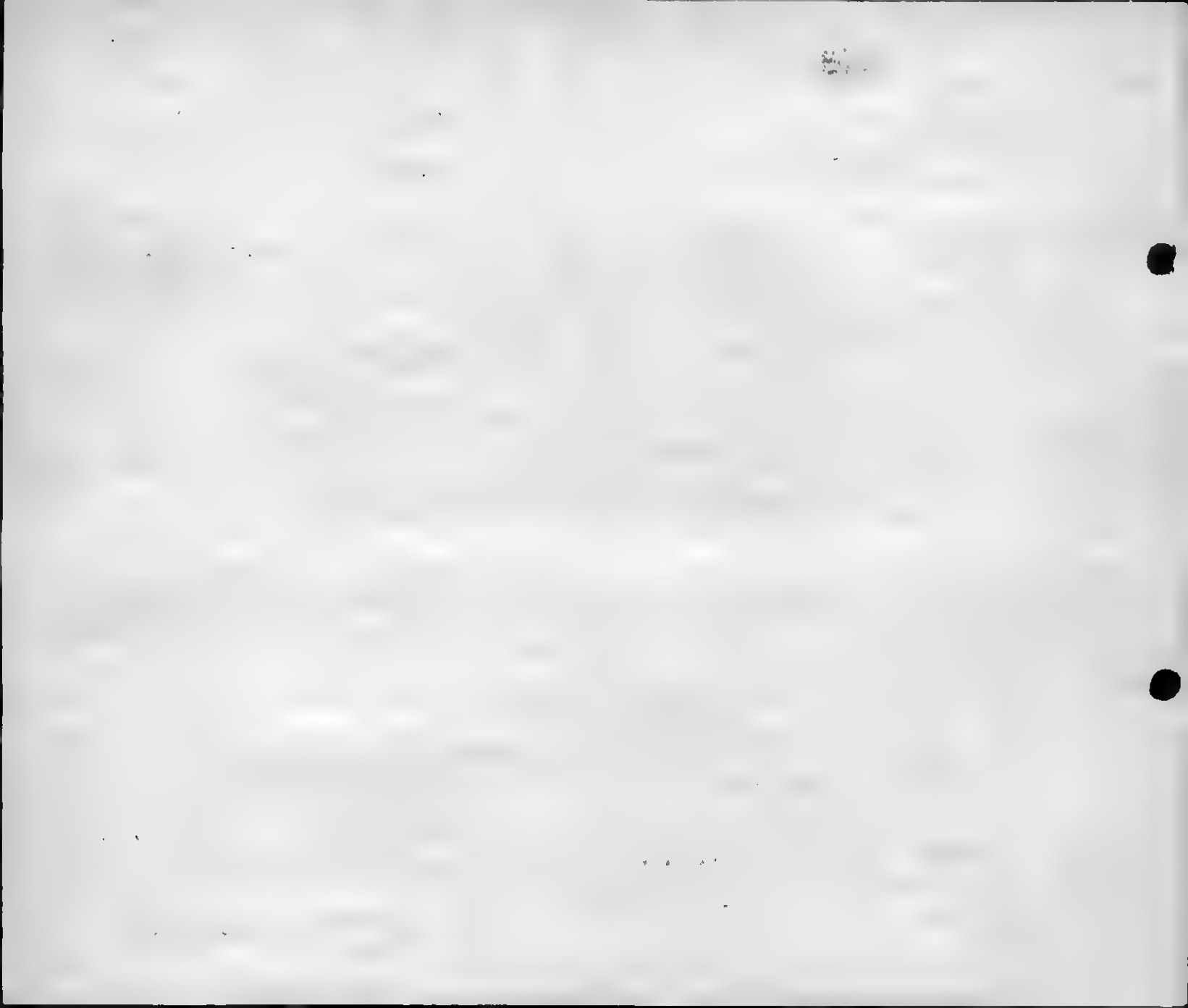
21. I certify that I took charge of the remains described above, held an **Autopsy** ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from **Natural causes** ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE **Peter W. Rieckert** CHIEF MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☐ DATE SIGNED **2/15/60**

EXAMINER'S NAME (Type) **Peter Rieckert, M.D.** Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 22b. DATE THEREOF **Feb. 17, 1960** 22c. NAME OF CEMETERY OR CREMATORY **Johnson Family Plot** 22d. LOCATION (City, town, or country) (State) **Pittsford, N.Y.**

23. FUNERAL DIRECTOR **W.H. Arthur** ADDRESS **13 Benson Rd.** 24a. DIED BY REGISTRAR **FEB 17 '60** 24b. REGISTRAR'S SIGNATURE **Arthur S. Harris** DATE **FEB 17 '60**



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

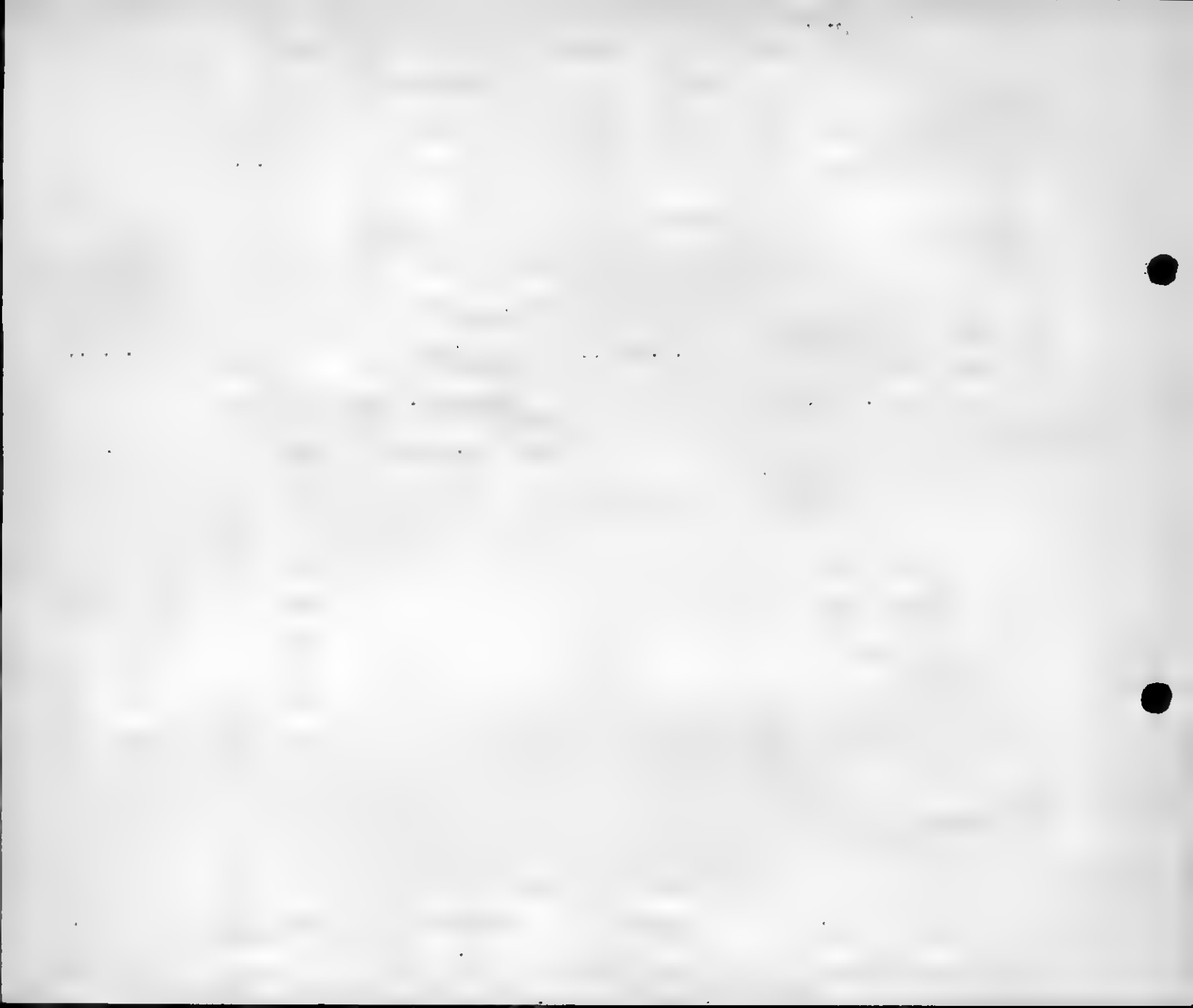
## 2079 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02063

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Harford</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Joppa</u> c. LENGTH OF STAY IN ID d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hollingsworth Road</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Joppa</u> R.D., Box # <u>178 A</u> d. STREET ADDRESS <u>Hollingsworth Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Howard</u> Middle <u>E</u> Last <u>Norton</u>		<b>4. DATE OF DEATH</b> Month <u>February</u> Day <u>25</u> Year <u>1960</u>		<b>5. SEX</b> <u>M</u>			
<b>6. COLOR OR RACE</b> <u>w</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>May, 10, 1901</u>			
<b>9. AGE</b> (in years last birthday) <u>58</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>		<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>U.S. Govt.,</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Illinois</u>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.,</u>				<b>13. FATHER'S NAME</b> <u>William W. Norton</u>			
<b>14. MOTHER'S MAIDEN NAME</b> <u>Hannah E. Borg</u>				<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (If yes, give war or dates of service) <u>no</u>			
<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <u>Sylvia A. Norton</u> Address <u>Joppa Maryland</u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>  </u> (c) <u>  </u> (a), stating the underlying cause last. DUE TO (b) <u>  </u> (c) <u>  </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>  </u> o. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u>			
<b>20f. (City or town)</b> <u>  </u>		<b>(County)</b> <u>  </u>		<b>(State)</b> <u>  </u>			
<b>21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.</b>							
<b>ACTUAL SIGNATURE</b> <u>Gerald C Palmer</u>		<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <u>BOA in M</u>		<b>DATE SIGNED</b> <u>2-25-60</u>			
<b>EXAMINER'S NAME (Type)</b> <u>Gerald C Palmer MD</u>		<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>		<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>Feb. 29, 1960</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Moreland Memorial Park</u>			
<b>22d. LOCATION (City, town, or county)</b> <u>Baltimore 14 Maryland</u>		<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Howard N. McCombs</u>					
<b>24a. REC'D BY REGISTRAR</b> <u>MAAM 1 60</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kirsch</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, and the certificate, writing the "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.



2057

## CERTIFICATE OF DEATH

Reg. Dist. No.

02064

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>PENNSYLVANIA</b> b. COUNTY <b>YORK</b>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>HAURE DE GRACE</b>		c. LENGTH OF STAY IN 1b <b>24 HRS.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>HARFORD MEMORIAL Hosp</b>		e. STREET ADDRESS <b>R.D. #1</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>CHARLES THOMAS PICKEL</b>		4. DATE OF DEATH Month Day Year <b>FEBRUARY 29 1960</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 6, 1882</b>
9. AGE (In years last birthday) <b>77</b> yrs		F UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PLUMBER</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>KATHERINE (Unknown)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>183-05-4033</b>	
INFORMANT Address <b>MRS. HERMAN FEW, DELTA, PA.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Posterior Myocardial Infarction</b> 4.1.1 DUE TO <b>Coronary Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Arteriosclerotic Cardiovascular Disease</b> (c) <b>Pneumonitis, bilateral</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>1 day</b> <b>?</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> 19 <b>p.m.</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb. 28th, 1960</b> to <b>Feb. 29th, 1960</b> that I last saw the deceased alive on <b>Feb. 29th, 1960</b> and that death occurred at <b>1229</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Edward C. Loo, M.D.</b>		A ADDRESS (Street, city or town, state) <b>211 N. Union Ave.</b> DATE SIGNED <b>3/29/60</b>	
PHYSICIAN'S NAME (Type) <b>Edward C. Loo, M.D.</b>		<b>Haure de Grace, Md.</b>	
22a. BURIAL, CREMATION, EXEMPTION (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>3-2-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>MT. OLIVET</b>	22d. LOCATION (City, town, or county) (State) <b>FAWN TWP. YORK CO., PA.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John H. Harkins</b>		ADDRESS <b>Delta, Pa.</b>	
24a. REC'D BY REGISTRAR DATE <b>MAR 3 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Thomas</b>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02065

2080

1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Harford</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Darlington</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Darlington</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Cedar Lane</b>				d. STREET ADDRESS <b>Cedar Lane</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Ella Poulson</b>				4. DATE OF DEATH Month <b>February</b> Day <b>25</b> Year <b>1960</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-3-1883</b>		9. AGE (In years last birthday) <b>76 yrs.</b>	10. IF UNDER 1 YEAR Months <b>76</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Webster</b>				14. MOTHER'S MAIDEN NAME <b>Mary Jane Kenley</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-01-5377A</b>		17. INFORMANT Address <b>Box 85</b> <b>Mr. John H. Webster, Darlington, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic C V Disease</b> DUE TO <b>12.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour _____ o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Gerald C Palmer</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Gerald C. Palmer M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 29, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Lane Cemetery</b>		22d. LOCATION (City, town, or county) <b>Darlington</b> (State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Elmer E. Bullake</b>				ADDRESS <b>House Co. House</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 1 '60</b>	
						24b. REGISTRAR'S SIGNATURE <b>Arthur L. Frank</b>	



## 2081 CERTIFICATE OF DEATH

Reg. Dist. No.

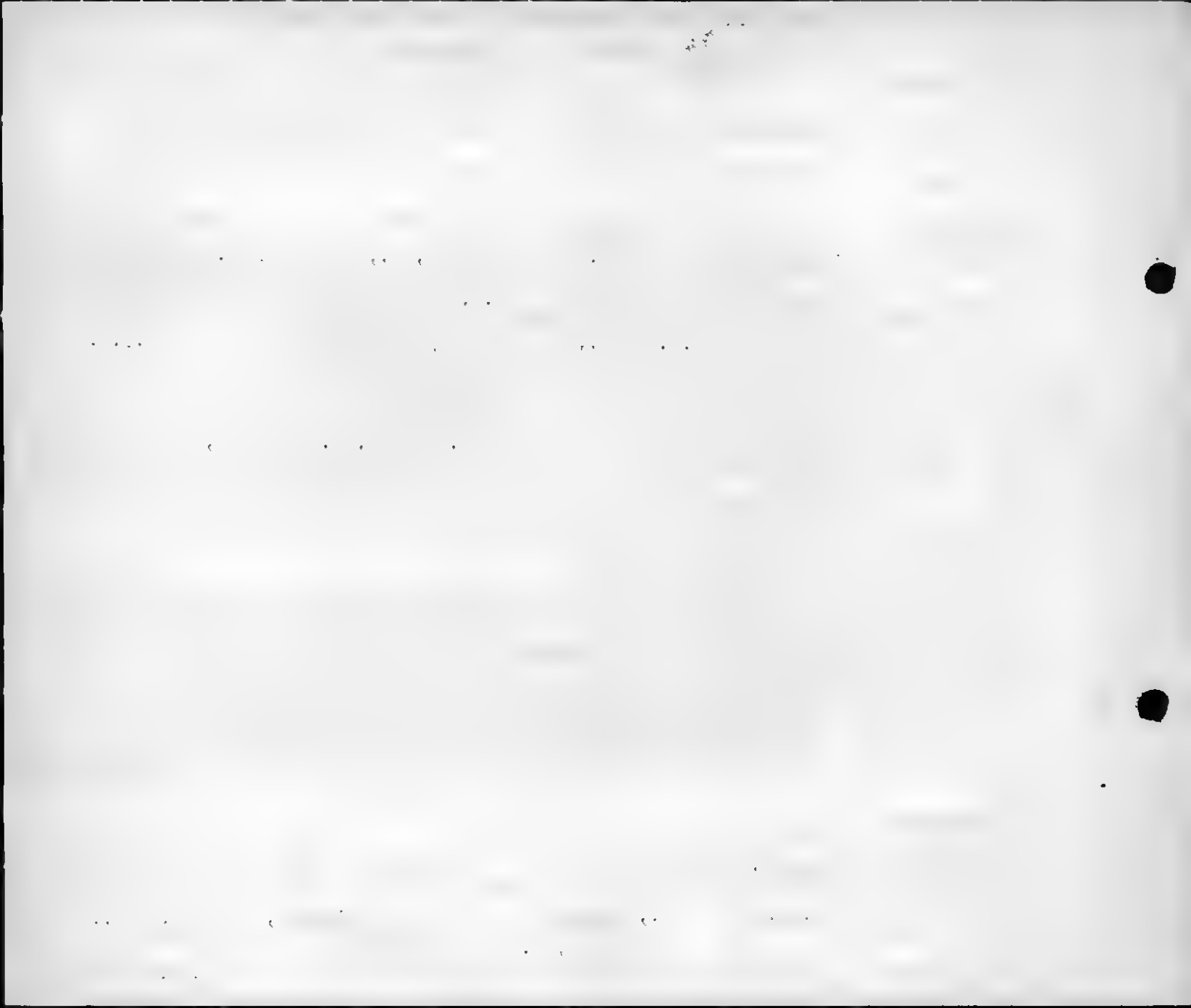
02066

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Joppa</u>				c. LENGTH OF STAY IN 1b <u>60 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>J.</u> Last <u>Powers, Sr.</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>13</u> Year <u>1960</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 8, 1876</u>	9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.,</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.,</u>	
13. FATHER'S NAME <u>Philip Powers</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>William J. Powers, Jr.,</u> Address <u>Joppa, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>422.1</u> IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>  </u> <u>  </u> <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>58</u> , to <u>Feb.</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Feb. 12</u> , 19 <u>59</u> , and that death occurred at <u>5:40 a.m.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>Feb. 15, 1960</u>							
ACTUAL SIGNATURE <u>William C. Tyson</u> M.D.				PHYSICIAN'S NAME (Type) <u>William A. Tyson</u> <u>Kingsville Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 15, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St., Francis</u>		22d. LOCATION (City, town, or county) (State) <u>Abingdon, Harford, Md.,</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard R. McCombs Jr.</u> ADDRESS <u>Abingdon, Md.,</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 17 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2058

## CERTIFICATE OF DEATH

Reg. Dist. No.

02067

<b>1. PLACE OF DEATH</b> a. COUNTY <u>HARFORD</u> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE</u>		c. LENGTH OF STAY IN 1b <u>11 HRS.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marketon Street</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL HOSP.</u>				d. STREET ADDRESS <u>1</u>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>GAIL</u> Middle <u>MARIE</u> Last <u>PRINGLE</u>				<b>4. DATE OF DEATH</b> Month <u>FEBRUARY</u> Day <u>24</u> Year <u>1960</u>			
<b>5. SEX</b> <u>FEMALE</u>		<b>6. COLOR OR RACE</b> <u>Colored</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>Feb. 19 1960</u>			
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>9. AGE</b> (In years last birthday) <u>4</u> yrs.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>INFANT</u>			
<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>None</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			
<b>13. FATHER'S NAME</b> <u>William Pringle</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Doris Jackson</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>—</u>		<b>17. INFORMANT</b> <u>Margaret Jackson</u> Address <u>Marketon Md</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>FIRX</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>emphysema</u> DUE TO (c) <u>lobes pneumonia left</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b> (County) (State)		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>					
<b>21. I certify that I attended the deceased from</b> <u>Feb 23</u> , 19 <u>60</u> , to <u>Feb 24</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Feb 24</u> , 19 <u>60</u> , and that death occurred at <u>3:50</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Marketon Md</u> DATE SIGNED <u>—</u>							
<b>ACTUAL SIGNATURE</b> <u>Phylis</u> M.D.							
<b>PHYSICIAN'S NAME (Type)</b> <u>DR. D. RITSAKIS MD</u>							
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>2/26/1960</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Union Chapel</u>			
<b>22d. LOCATION</b> (City, town, or county) (State) <u>Marketon Md.</u>		<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> ADDRESS <u>Charles E. Kurt Jarrettsville Md.</u>					
<b>24a. REC'D BY REGISTRAR</b> DATE <u>MAR 1 '60</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



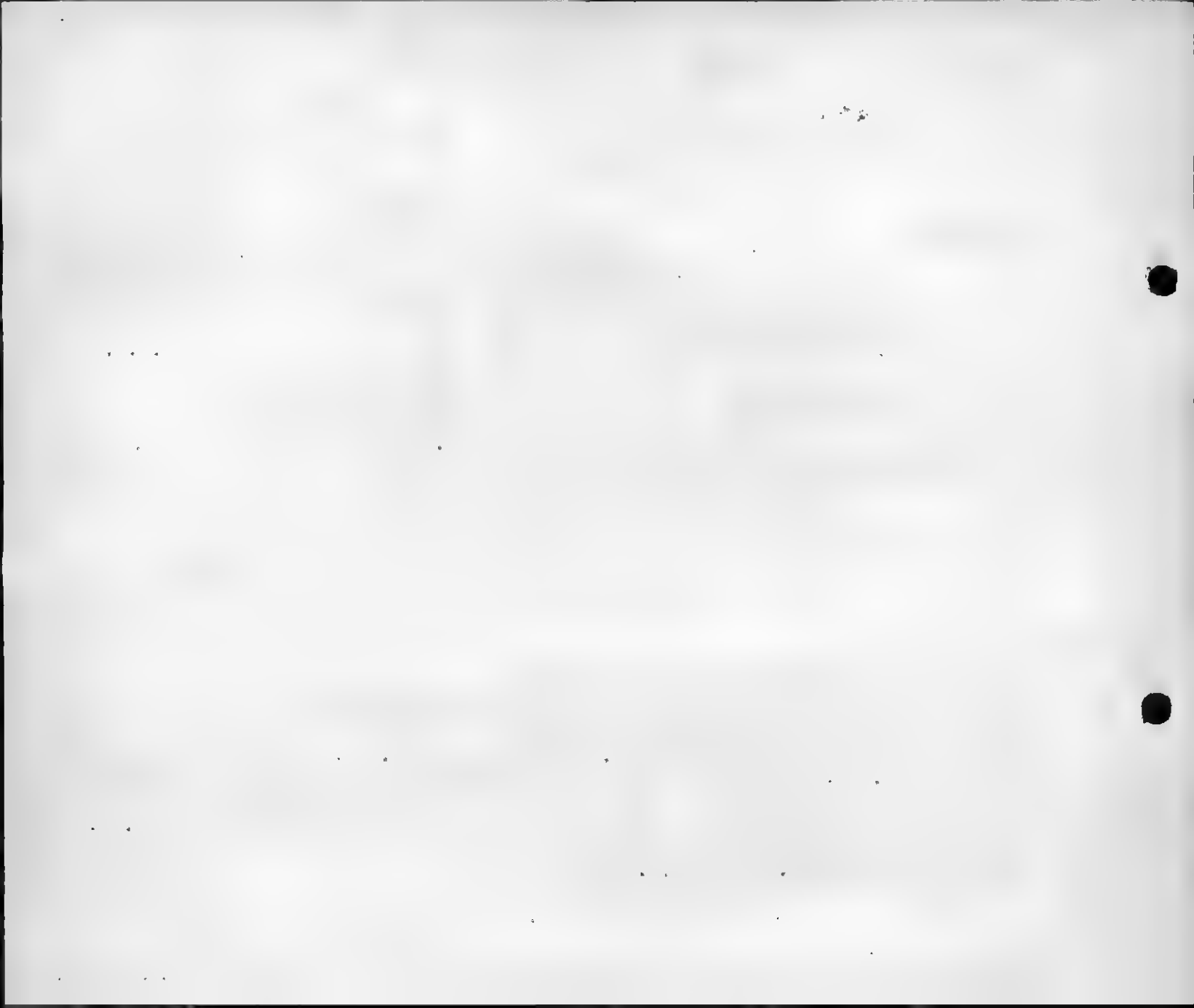
## 2082 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Harford</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Edgewood</b>				c. LENGTH OF STAY IN 1b <b>28 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Cordelia</b> Middle <b>Sarah</b> Last <b>Pugh</b>				4. DATE OF DEATH Month <b>February</b> Day <b>12</b> Year <b>1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 1, 1879</b>		9. AGE (In years last birthday) <b>80 yrs</b>	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Marshall Rouse</b>				14. MOTHER'S MAIDEN NAME <b>Matilda Sturgill</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT <b>Ambrose F. Pugh</b> Address <b>Edgewood, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) <b>Chronic Cardio-vascular disease with hypertension</b> ? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb. 10, 1950</b> , to <b>Feb. 12, 1960</b> , that I last saw the deceased alive on <b>Feb. 12, 1960</b> , and that death occurred at <b>10:00</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>Willard P. Hudson</b> M.D.				Forest Hill, Maryland Feb. 13, 1960			
PHYSICIAN'S NAME (Type) <b>Willard P. Hudson, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/15/1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Bel Air Mem. Gardens</b>		22d. LOCATION (City, town, or county) (State) <b>Bel Air, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles E. Gutz</b>				ADDRESS <b>Parrettsville Md</b>		24a. REC'D BY REGISTRAR <b>DATE FEB 16 '60</b>	
						24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2059

## CERTIFICATE OF DEATH

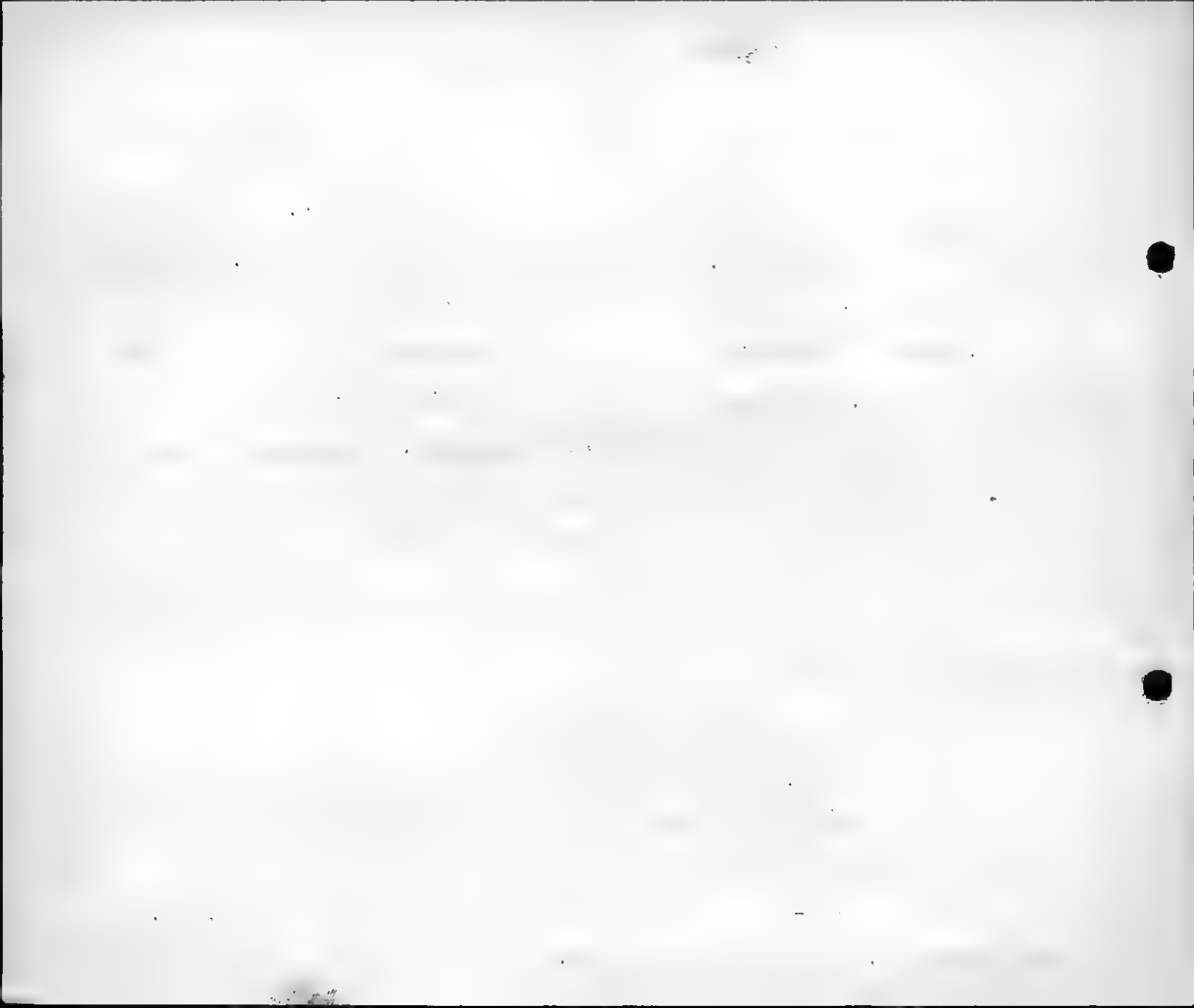
Reg. Dist. No.

02069

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Harford</b>		c. LENGTH OF STAY IN 1b <b>31</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Harford Memorial Hospital</b>		e. STREET ADDRESS <b>639 Andrews Rd.</b>	
3. NAME OF DECEASED (Type or print) First <b>Arthur J.</b> Middle <b>Pumphrey</b> Last <b></b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>12</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 9, 1920</b>
9. AGE (In years last birthday) <b>39</b> yrs.		10. IF UNDER 1 YEAR: Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Insurance salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b></b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Lee H. Pumphrey</b>		14. MOTHER'S MAIDEN NAME <b>Mary Griffin</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b></b>		16. SOCIAL SECURITY NO. <b>216 01 6112</b>	
17. INFORMANT <b>Frances E. Pumphrey</b>		Address <b>same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) <b>Coronary Occlusion</b> <b>Coronary Thrombosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b> <b>1 hour</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b></b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b></b>		20f. (City or town) (County) (State) <b></b>	
21. I certify that I attended the deceased from <b>(P. 53)</b> 19 <b>60</b> to <b>2-12-</b> 19 <b>60</b> that I last saw the deceased alive on <b>2-12-</b> 19 <b>60</b> and that death occurred at <b>10:50 AM</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Peter P. Rodman, M.D.</b>		DATE SIGNED <b>2-12-60</b>	
PHYSICIAN'S NAME (Type) <b>Peter P. Rodman, M.D.</b>		<b>Abbeeden, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	22b. DATE THEREOF <b>2-16-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Nat'l</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Ruck</b>		24. REC'D BY REGISTRAR: <b>Feb 18 60</b>	
Address <b>5305 Harford Rd.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



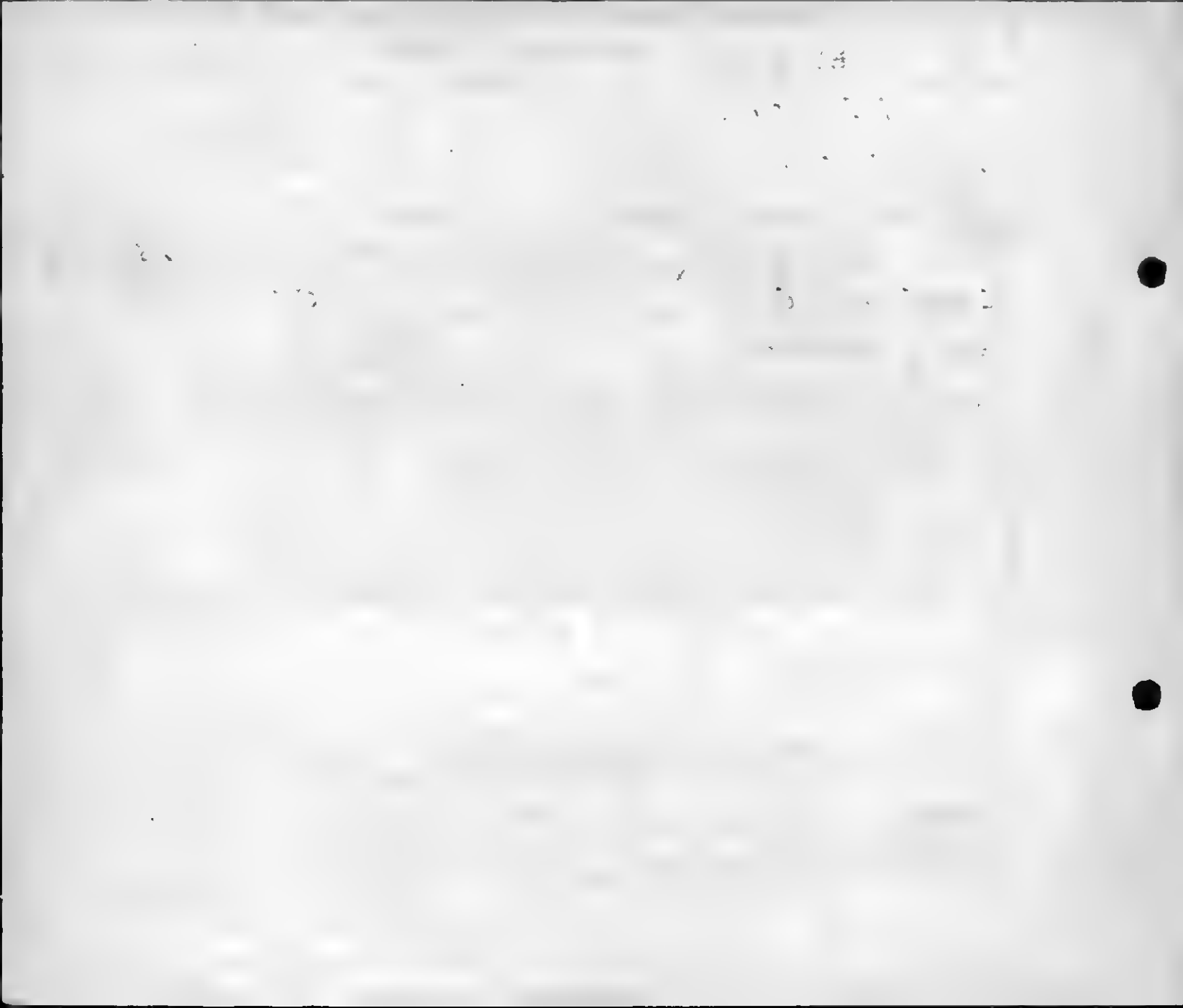
## CERTIFICATE OF DEATH

Reg. Dist. No. 02070

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harpe-de-Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harpe-de-Grace</u>	
c. LENGTH OF STAY IN 1b <u>16 days</u>		d. STREET ADDRESS <u>418 N. Stokes St.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hartford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Margaret Butler Reeves</u>		4. DATE OF DEATH Month <u>2</u> Day <u>18</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 2 - 1902</u> yrs. <u>57</u>
9. AGE (In years last birthday) <u>57</u> yrs.		10. IF UNDER 1 YEAR: IF UNDER 24 HRS: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Beauty Shop owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Davis White Lock</u>		14. MOTHER'S MAIDEN NAME <u>Della Hasson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>Unknown</u>	
17. INFORMANT <u>418 N. Stokes St. Harpe-de-Grace Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Tuberculosis</u>		DUE TO <u>Militeris - myocarditis</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Pneumonia (flu)</u>		(b) <u>Pneumonia (flu)</u>	
(c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Feb 9th</u> , 19 <u>60</u> , to <u>Feb 18</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Feb 18</u> , 19 <u>60</u> , and that death occurred at <u>M</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. L. Lume MD</u>		ADDRESS (Street, city or town, state) <u>Harpe-de-Grace MD 21-60</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE, THEREOF <u>2/22/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Gethsemane</u>	22d. LOCATION (City, town, or county) (State) <u>Pineville, MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James H. R. Howard</u>		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE <u>John S. H. H.</u>
DATE <u>FEB 24 '60</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02071

2083

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Va</u> b. COUNTY <u>Marion</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL Bel Air</u>				c. LENGTH OF STAY IN 1b <u>2 weeks</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Ruff Mill Road</u>				e. STREET ADDRESS <u>85X</u>			
3. NAME OF DECEASED (Type or print) <u>Herman E Richardson</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>28</u> Year <u>1960</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 17, 1918</u>	
9. AGE (In years last birthday) <u>41</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attendant</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert J.F. Richardson</u>				14. MOTHER'S MAIDEN NAME <u>Audie MAE Eller</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>224-20-2879</u>		17. INFORMANT <u>Mr. John W. Lowman</u> Address <u>Ruffs Mill Road (brother-in-law)</u> <u>RD., Bel Air, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GSW chest</u> 976X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>2-28</u> p. m. <u>60</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Ruffs Mill Rd</u>		20f. (City or town) (County) (State) <u>Bel Air Harford Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> <del>suicide</del> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>2-28-60</u>			
EXAMINER'S NAME (Type) <u>Gerald C Palmer M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 2, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Reland Creek Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Smith County Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Fister</u> ADDRESS <u>30 Broadway + Williams St. Bel Air, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 1 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please excuse the certificate, writing this and "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

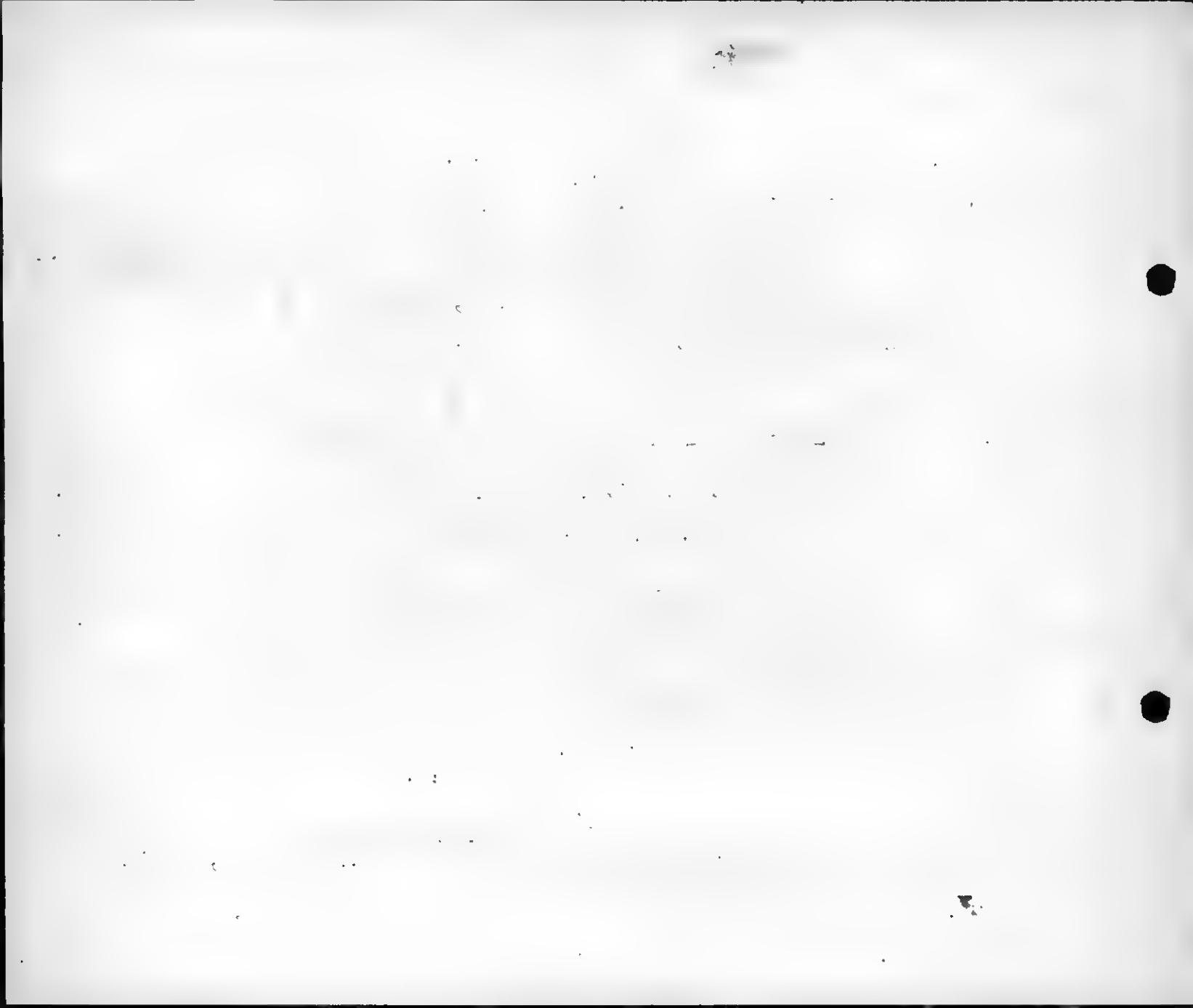
2084

CERTIFICATE OF DEATH

Reg. Dist. No. 02072

1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Ohio</b> b. COUNTY <b>Coshocton</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen</b>		c. LENGTH OF STAY IN lb <b>3 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>US Army Hospital Aberdeen Proving Ground, Md</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>NORMAN</b> Middle <b>EUGENE</b> Last <b>RODGERS</b>		4. DATE OF DEATH Month <b>February</b> Day <b>2</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug 13, 1935</b>
9. AGE (In years last birthday) <b>24</b> yrs.		10. IF UNDER 1 YEAR Months <b>24</b> Days <b>24</b> Hours <b>24</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Soldier - Pvt</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>US Army</b>	
11. BIRTHPLACE (State or foreign country) <b>Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Rodgers</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO <b>283-26-1255</b>	
17. INFORMANT <b>Official Army Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute ventricular fibrillation</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>acute myocardial infarction</b> DUE TO (c) <b>arteriosclerotic heart disease</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 hours</b> <b>16 hours</b> <b>unknown</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2 February, 1960</b> , to <b>2 February, 1960</b> , that I last saw the deceased alive on <b>2 February, 19 60</b> , and that death occurred at <b>3:00P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>US Army Hospital Aberdeen Proving Ground, Maryland</b> <b>2 Feb 60</b>			
ACTUAL SIGNATURE <b>Joseph A Grossman</b> M.D.		PHYSICIAN'S NAME (Type) <b>JOSEPH A GROSSMAN Capt MC</b>	
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>2/4/60</b>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) <b>Coshocton, Ohio</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John E. Tenney</b>		ADDRESS <b>Chardon, Md</b>	
24a. REC'D BY REGISTRAR DATE <b>FEB 5 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Carlton L. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)  
SM 9/55

# 2061 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02073

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>		c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u> Rural		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>			d. STREET ADDRESS <u>Carsin Run Road</u>		
3. NAME OF DECEASED (Type or print) First <u>Herman</u> Middle <u>A.</u> Last <u>Skillman Jr</u>			4. DATE OF DEATH Month <u>February</u> Day <u>12</u> Year <u>1960</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-31-43</u>	9. AGE (in years last birthday) <u>16</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (State or foreign country) <u>Harford Co., Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Herman A. Skillman, Sr.,</u>			14. MOTHER'S MAIDEN NAME <u>Sylvia Bem</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT <u>Herman A. Skillman, Sr.,</u> Address <u>Aberdeen R.D., Md.,</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture skull</u> <u>523X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident - CV - 1st floor - road</u>			
20c. TIME OF INJURY Month, Day, Year <u>Hour 3:35 p.m. 2-12-60</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Tollgate Road</u>	20f. (City or town) <u>Belt Air</u>	(County) <u>Harford</u>	(State) <u>Md</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>Ronald E Palmer</u> M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>2-13-60</u>
EXAMINER'S NAME (Type) <u>Ronald E Palmer M.D.</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Feb 16, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Francis</u>		22d. LOCATION (City, town, or county) (State) <u>Abingdon, Harford, Md.,</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. McKenney Jr</u>		ADDRESS <u>Abingdon, Md.,</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 17 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kneass</u>



2062

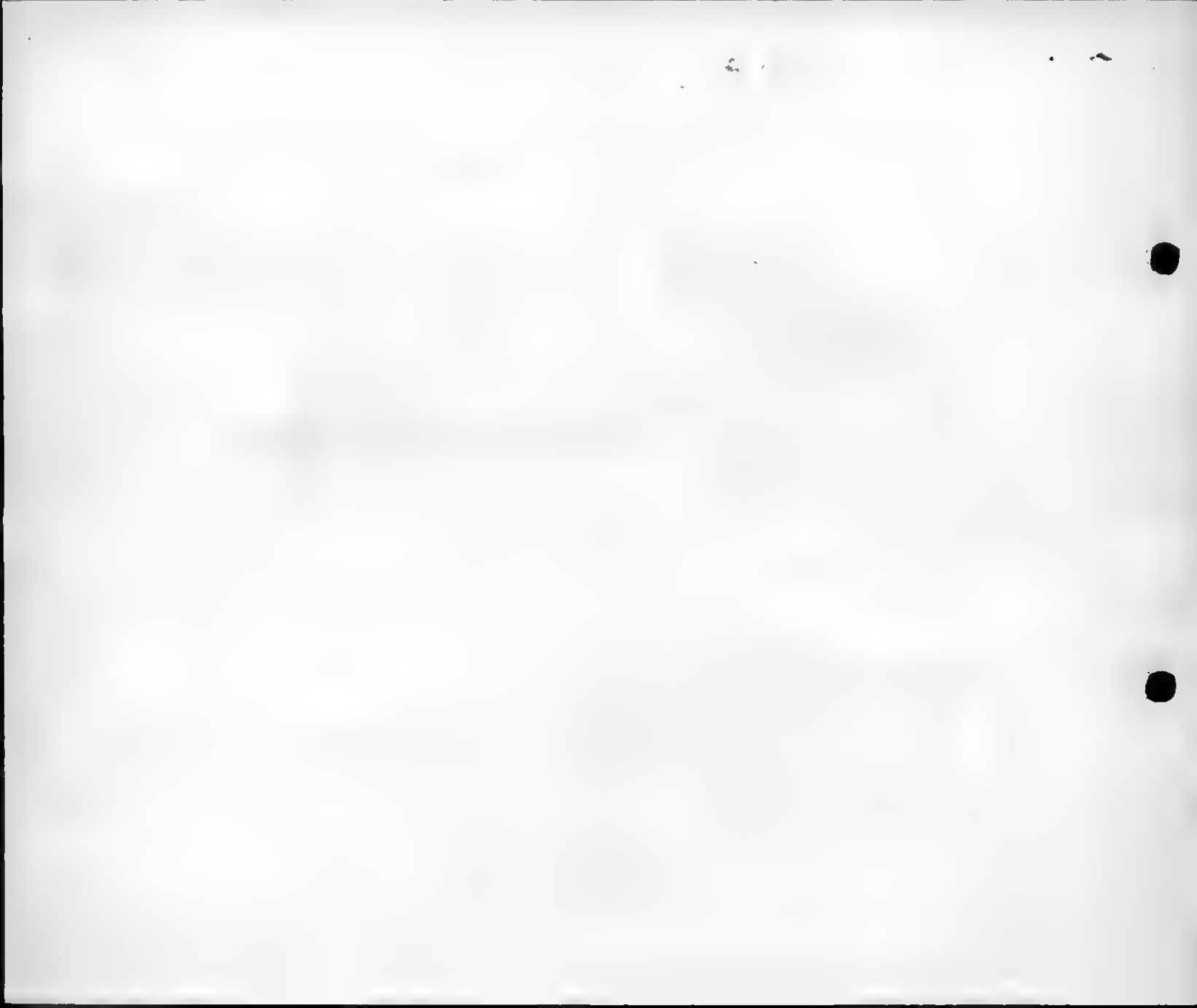
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>		c. LENGTH OF STAY IN 1b <u>2 1/4 hrs.</u>	
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Stansbury Nellie L. Stansbury</u>		4. DATE OF DEATH Month Day Year <u>Feb. 9 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 18-1898</u>
9. AGE (In years last birthday) <u>61</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Keeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u> Lloyd Thomas Scourion</u>		14. MOTHER'S MAIDEN NAME <u>Harriett Paseo</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>219-03-4924</u>	
17. INFORMANT <u>Marie Pahl</u> Address <u>800 Garfield Rd Harre de Grace</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Massive Cerebral Hemorrhage</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular disease</u> DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 3</u> , 19 <u>59</u> , to <u>Feb. 9</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Feb. 9</u> , 19 <u>60</u> , and that death occurred at <u>4:05 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George T. Stansbury</u>		ADDRESS (Street, city or town, state) <u>559 Revolution St. Harre de Grace, Md.</u> DATE SIGNED <u>2/9/60</u>	
PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/13/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Wet Calvary</u>	22d. LOCATION (City, town, or county) (State) <u>Aberdeen Rural Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Barrington - Aberdeen Maryland</u>		24a. REC'D BY REGISTRAR <u>Feb 16 '60</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kinn</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2063

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>UNCLERED</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>4141-41-41-41</u>		2. USUAL RESIDENCE (Where deceased lived If institution Res. dence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
c. LENGTH OF STAY IN 1b <u>07 x</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perryville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>071 HOFFORD Memorial Hosp</u>		d. STREET ADDRESS <u>Franklin St</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Leonard Arnold Sumpter</u>		4. DATE OF DEATH Month Day Year <u>Feb. 10 1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/10/60</u>
9. AGE (In years last birthday) yrs <u>4</u>		10. IF UNDER 1 YEAR Months Days <u>4 35</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Oakley A. Sumpter Jr.</u>		14. MOTHER'S MAIDEN NAME <u>Ellen M. Thompson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <u>NO</u>		16. SOCIAL SECURITY NO. <u>INFORMANT</u> <u>Oakley A. Sumpter Jr. Perryville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>HYALINE MEMBRANE DISEASE</u> <u>769.6</u> DUE TO (b) <u>PREMATURITY</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>MATERNAL DIABETES MELLITUS</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ELECTIVE CESAREAN SECTION - PREMATURE SEPARATION PLACENTA</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10 FEB</u> , 19 <u>60</u> , to <u>10 FEB</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>10 FEB</u> , 19 <u>60</u> , and that death occurred at <u>7:15 P.</u> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>R. B. Norment M.D.</u> <u>2/10/1960</u> <u>Havre de Grace, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/11/1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Asbury Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Port Deposit, Md. Rural</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Rosa Patterson &amp; Son</u>		24a. REC'D BY REGISTRAR <u>FEB 12 '60</u>	
ADDRESS <u>Perryville, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. S. Kline</u>	

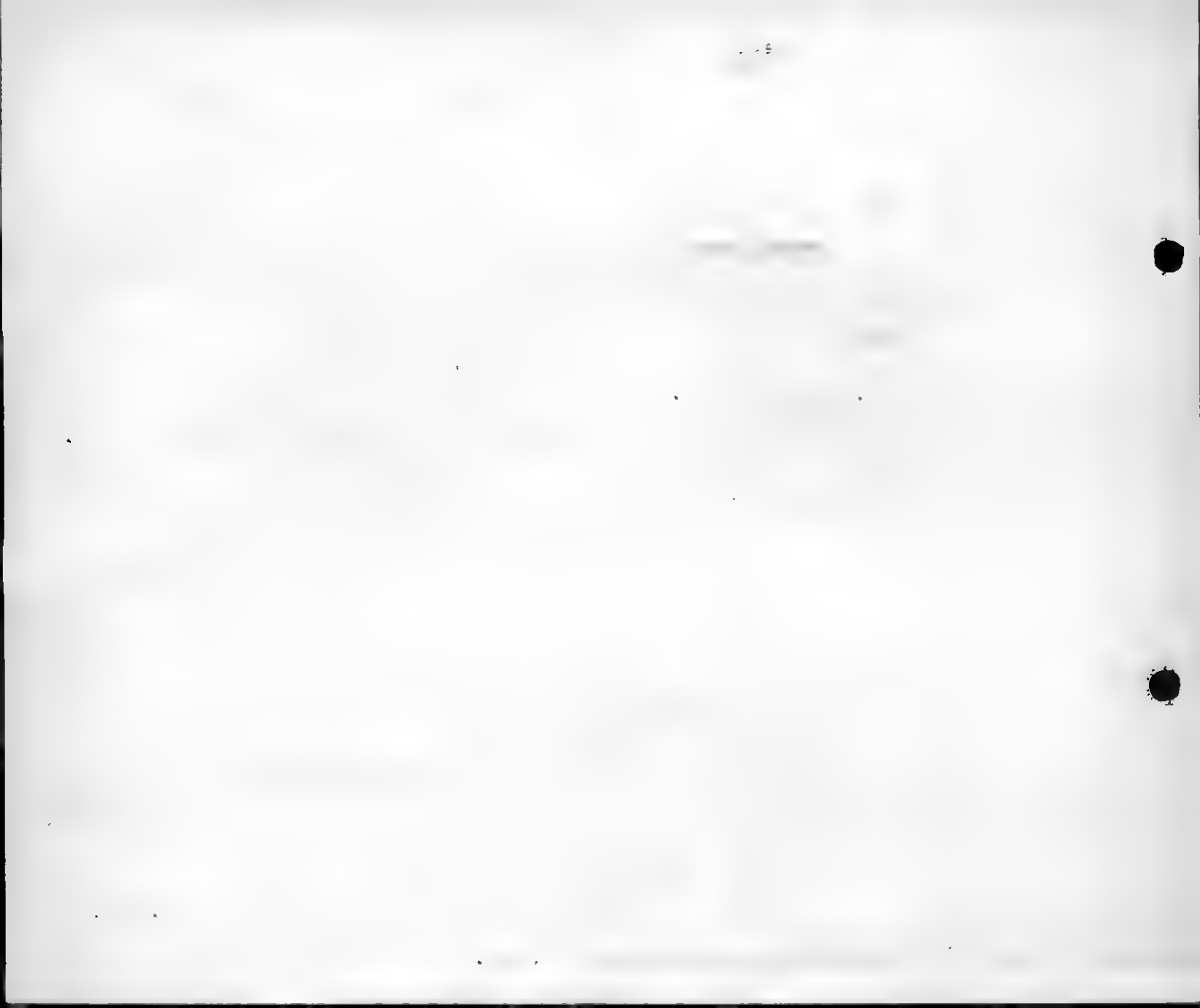
1

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VS A15 (4)  
JSM 9/58

2071251XV3



## CERTIFICATE OF DEATH

Reg. Dist. No.

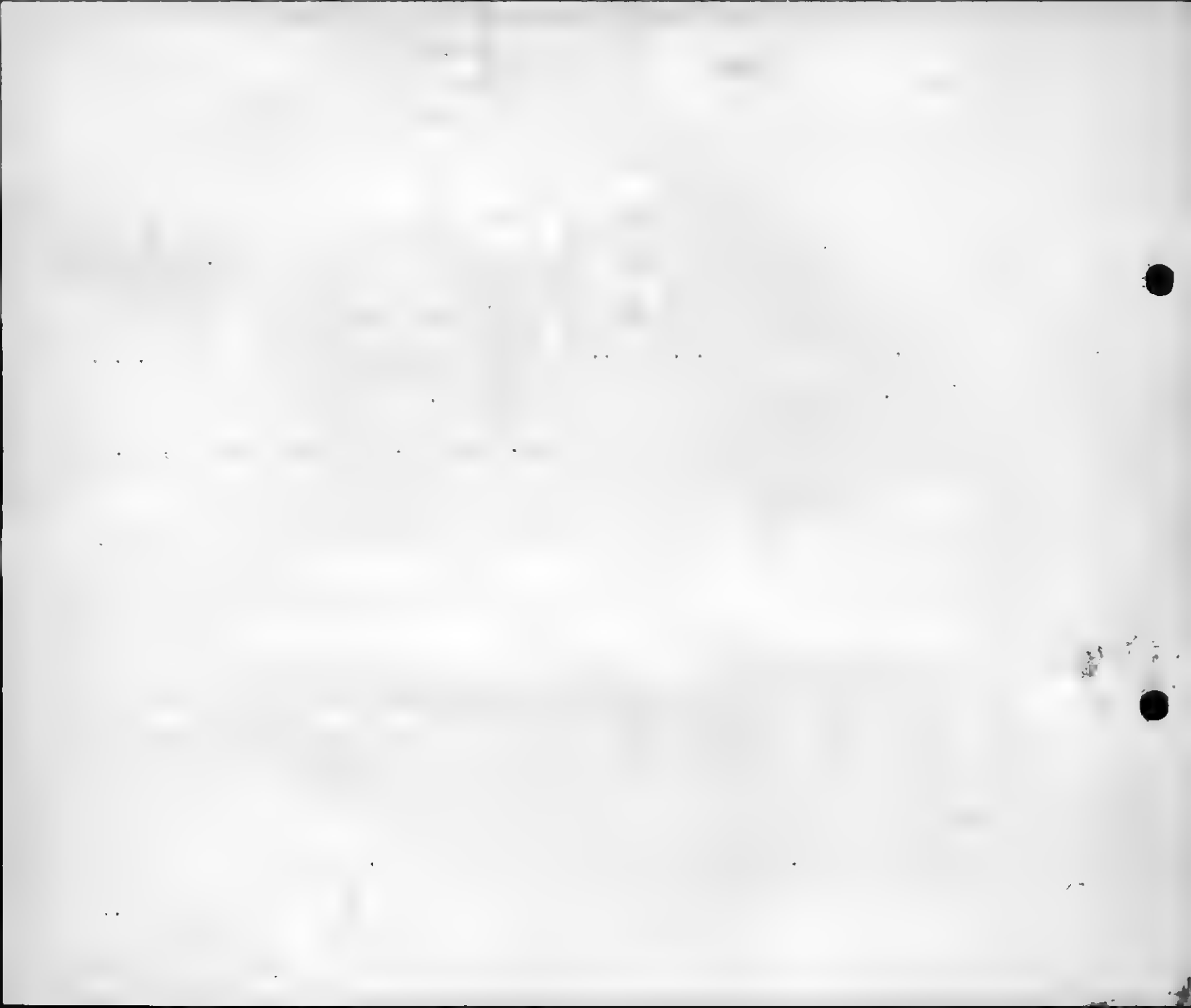
02076

2085

1. PLACE OF DEATH a. COUNTY <u>Harford</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Magnolia</u> c. LENGTH OF STAY IN 1b <u>Lifetime</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Magnolia</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>OSCAR</u> Last <u>TIMMONS</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>11</u> Year <u>19 60</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 10, 1882</u>
9. AGE (In years last birthday) yrs. <u>77</u>		10. IF UNDER 1 YEAR Months <u>11</u> Days <u>19</u> Hours <u>60</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman, Railroad</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.,</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.,</u>	
13. FATHER'S NAME <u>John E. Timmons</u>		14. MOTHER'S MAIDEN NAME <u>Mary L.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Martha P. Timmons</u>		Address <u>Magnolia, Md.,</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>334X Hemiplegia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arterial sclerosis</u> DUE TO (c) <u>diabetes m.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>10 yrs</u> <u>1 year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 1</u> , 195 <u>8</u> , to <u>Feb 11</u> , 196 <u>0</u> , that I last saw the deceased alive on <u>Feb 11</u> , 196 <u>0</u> , and that death occurred at <u>5 P.</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Fred O. Hodus</u>		ADDRESS (Street, city or town, state) <u>Edgewood, Md.</u> DATE SIGNED <u>2-12-60</u>	
PHYSICIAN'S NAME (Type) <u>Fred O. Hodus</u>		<u>Edgewood, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Feb 14, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mountain Christian</u>	22d. LOCATION (City, town, or county) (State) <u>Joppa, Harford, Md.,</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. McRae Jr.</u>		ADDRESS <u>Abingdon, Maryland</u>	
24a. REC'D BY REGISTRAR <u>DATE FEB 17 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2064

## CERTIFICATE OF DEATH

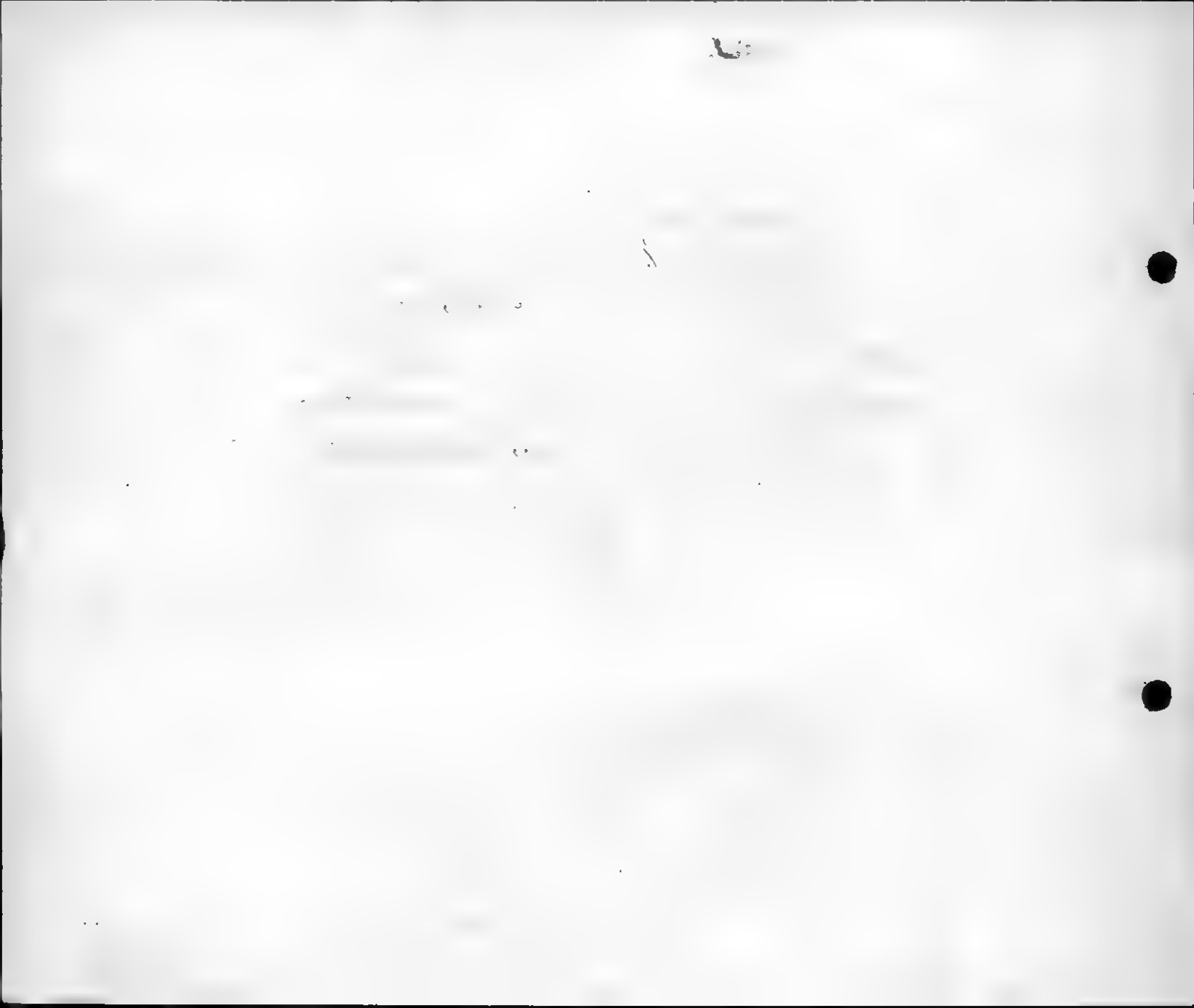
Reg. Dist. No.

02077

1. PLACE OF DEATH a. COUNTY <u>Harford</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Harford</u>	
c. LENGTH OF STAY IN 1b <u>19 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Joppa</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OF INSTITUTION <u>Harford Memorial Hospital</u>		d. STREET ADDRESS <u>St 7</u>	
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>D.</u> Last <u>Townsley</u>		4. DATE OF DEATH Month <u>February</u> Day <u>14</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 29, 1909</u>
9. AGE (In years last birthday) <u>51</u> yrs		FUND 1 YEAR IF UNDER 24 HRS Months <u>1</u> Days <u>14</u> Hours <u>14</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>	
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Charles Shirey</u>		14. MOTHER'S MAIDEN NAME <u>Amanda Jones</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Wm., Arthur Townsley</u>		Address <u>Joppa Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Decompensation</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>A.S.C. V.D.</u> DUE TO (c) <u>—</u>		INTERVA. BETWEEN ONSET AND DEATH <u>2 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>—</u>	
20c. TIME OF INJURY Month, Day Year Hour a. m. <u>—</u> p. m. <u>—</u> 19 <u>60</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bridge, etc.) <u>—</u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan. 27</u> , 19 <u>60</u> , to <u>Feb. 14th</u> , 19 <u>60</u> that I last saw the deceased alive on <u>Feb. 14</u> , 19 <u>60</u> and that death occurred at <u>12:30 P.M.</u> from the causes and on the date stated above			
ACTUAL SIGNATURE <u>Edward E. Loo, M.D.</u>		DATE SIGNED <u>2/14/60</u>	
PHYSICIAN'S NAME (Type) <u>Edward E. Loo, M.D.</u>		ADDRESS (Street, city or town, state) <u>211 N. Union Ave. Harford Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 18, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>		22d. LOCATION (City, town, or county) (State) <u>Bel Air Harford Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward E. Loo</u>		24a. REC'D BY REGISTRAR <u>—</u> DATE <u>FEB 23 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>—</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove section papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event with in 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2065

CERTIFICATE OF DEATH

Reg. Dist. No.

02078

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b> <b>HARFORD</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAURE DE GRACE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>31 Aberdeen</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>071 HARFORD MEMORIAL Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>IDA</b> Middle <b>E</b> Last <b>VAUGHT</b>		4. DATE OF DEATH Month <b>FEB.</b> Day <b>26</b> Year <b>1960</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 13, 1894</b>
9. AGE (In years last birthday) <b>65</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>NORTH CAROLINA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Rutherford</b>		14. MOTHER'S MAIDEN NAME <b>Susan Parks</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-18-2193</b>	
17. INFORMANT <b>Fred T. Vaught, Aberdeen, Md.</b>		229 Baltimore St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <b>24 hr.</b> <b>3 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1956</b> , 19, to <b>2-26</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>2-24</b> , 19 <b>60</b> , and that death occurred at <b>10:50 PM</b> . From the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>8 Law Street</b> DATE SIGNED <b>2-29-60</b>			
ACTUAL SIGNATURE <b>Peter P. Rodman</b>		M.D. <b>8 Law Street</b>	
PHYSICIAN'S NAME (Type) <b>Peter P. Rodman, M.D.</b>		<b>Aberdeen, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1 Mar. 60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Bakers Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Aberdeen, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John S. Tarring</b>		24a. REC'D BY REGISTRAR <b>MAR 2 '60</b>	
ADDRESS <b>Aberdeen, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Clifton S. Kiana</b>	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2086

CERTIFICATE OF DEATH

02079

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>HARFORD</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL NORRISVILLE</b>				c. LENGTH OF STAY IN 1b <b>20 YRS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL NORRISVILLE</b>			
3. NAME OF DECEASED (Type or print) First <b>BETSY</b> Middle <b>H.</b> Last <b>WALDRON</b>				4. DATE OF DEATH Month <b>2</b> Day <b>13</b> Year <b>1960</b>			
5. SEX <b>F.</b>		6. COLOR OR RACE <b>W.</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-19-1893</b>	
9. AGE (In years last birthday) <b>66</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>JAMES HANKINS</b>				14. MOTHER'S MAIDEN NAME <b>SARAH BANDY</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>166-12-4719</b>		17. INFORMANT Address <b>James Waldron Stewartstown Rd, Pa</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis, secondary</b> <b>153.8</b> DUE TO <b>to carcinoma of colon</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <b>5</b> p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Stewartstown, Pa.</b>				20g. (County) <b>Harford Co., Md.</b>		20h. (State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>Sept.</b> <b>1959</b> to <b>Feb.</b> <b>1960</b> , that I last saw the deceased alive on <b>11 Feb.</b> <b>1960</b> , and that death occurred at <b>10:30 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Reginald B. Gemmill</b> M.D.				DATE SIGNED <b>13 Feb. 1960</b>			
PHYSICIAN'S NAME (Type) <b>REGINALD B. GEMMILL</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>2-16-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>NORRISVILLE</b>		22d. LOCATION (City, town, or county) (State) <b>NORRISVILLE HARFORD CO., MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Kenneth W. Ashburn</b>				ADDRESS <b>STEWARTSTOWN, PA</b>		24a. REC'D BY REGISTRAR <b>DATE FEB 16 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Charles S. Thomas</b>							

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